



**Dora**  
Department of Regulatory Agencies

**MARKET CONDUCT EXAMINATION REPORT**  
**Dated March 4, 2011**

**COVERING THE TIME PERIOD OF JULY 1, 2007 THROUGH JUNE 30,  
2009**

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**HUMANA HEALTH PLAN, INC.**

500 West Main Street  
Louisville, Kentucky 40202

**NAIC Company Code 95885**  
**NAIC Group Code 119**



**CONDUCTED BY:**

**COLORADO DIVISION OF INSURANCE**

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**HUMANA HEALTH PLAN, INC.**

**MARKET CONDUCT  
EXAMINATION REPORT  
DATED MARCH 4, 2011  
COVERING THE TIME FRAME OF JULY 1, 2007 THROUGH JUNE 30, 2009**

**Examination Performed by:**

**State Market Conduct Examiner**

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Examiner-In-Charge**

**And**

**Independent Contract Examiners**

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**Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP, ACS, MCM, PHIAS**

**Howard Quinn, AIE, CCP, CLU, ChFC**

**Lynn Zukus, AIE, FLMI**

March 4, 2011

The Honorable John J. Postolowski  
Interim Commissioner of Insurance  
State of Colorado  
1560 Broadway, Suite 850  
Denver, Colorado 80202

Commissioner Postolowski:

This market conduct examination of Humana Health Plan, Inc. ("Humana"), was conducted pursuant to §§ 10-1-203, 10-1-204, 10-1-205, 10-3-1106, and 10-16-416, C.R.S., which authorize the Insurance Commissioner ("Commissioner") to examine any entity engaged in the business of insurance, including health maintenance organizations. Humana's records were examined at the offices of Humana Insurance Company located at 1100 Employers Blvd, De Pere, WI 54344. The examiners also reviewed selected electronic records off-site. The market conduct examination covered the period from July 1, 2007 through June 30, 2009.

The following market conduct examiners respectfully submit the results of the examination.

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Kathleen M. Bergan, CIE, MCM

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**COMPANY PROFILE**

Humana Health Plan, Inc. (“Humana”) was incorporated under the laws of the Commonwealth of Kentucky on August 23, 1982 and commenced business on September 23, 1983. The Company is a wholly owned subsidiary of Humana Inc. with corporate headquarters located in Louisville, KY.

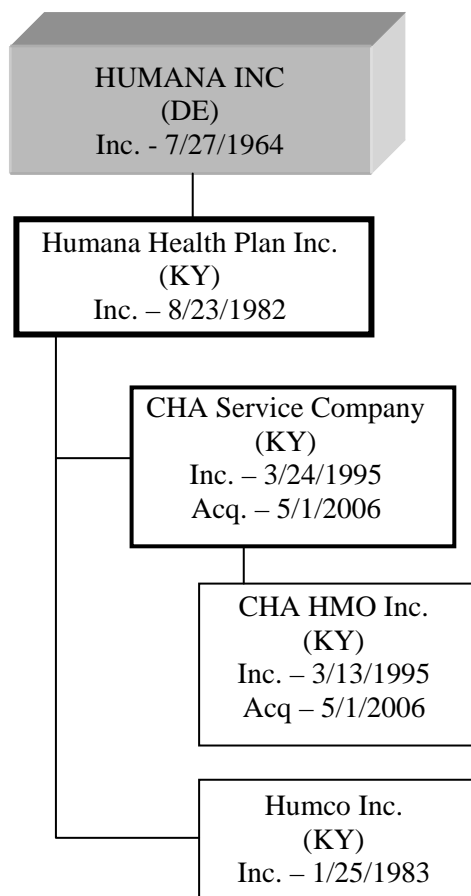
As a member of the Humana holding company system, the Company has numerous affiliates.

Humana obtained a Certificate of Authority with the Colorado Division of Insurance on June 25, 1987 and is currently licensed in the following counties: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Elbert, Fremont, Jefferson, Larimer, Mesa, Pueblo, Teller and Weld.

In addition to Colorado, Humana is licensed in seventeen (17) other states: Alabama, Arkansas, Arizona, Idaho, Illinois, Indiana, Kansas, Kentucky, Missouri, Nebraska, New Mexico, Nevada, South Carolina, South Dakota, Tennessee, Virginia and Washington.

**STRUCTURE AS OF JUNE 30, 2009**

An abbreviated organizational chart depicting Humana’s relationship with its ultimate controlling person and other affiliates, as of June 30, 2009 is presented below:



**Plan of Operation:**

Humana's health care service products are offered on a group basis. All marketing, advertising and sales activities are performed by Humana, Inc. a Delaware limited liability company, for the Company under the terms of the Administrative Service Agreement with the affiliates and the parent.

**Health Care Delivery:**

Humana is licensed to operate as a health maintenance organization (HMO) in Colorado and does not offer individual products.

As an Individual Practice Association (IPA) model HMO, Humana contracts directly with a broadly dispersed group of physicians to provide services to enrollees at the physicians' facilities. Humana also contracts with other health care providers and provider organizations to provide comprehensive health care benefits to enrollees.

The following shows Humana's enrollment, written premium and market share for the period under examination:

<u>Year</u>	<u>Number of Subscribers</u>	<u>Total Written Premium</u>	<u>Market Share</u>
2007	452	317,000	0.01%*
2008	16,234	39,613,000	1.03%*
2009	25,420	83,751,000	2.07%*

\*As shown in the 2007, 2008, and 2009 editions of the Colorado Insurance Industry Statistical Report.

During the examination, the examiners requested from Humana the reasons for the large increases in premium and business volume for the period under review. Humana stated that it was starting to gravitate its small and large group business from the affiliate Humana Insurance Company to the HMO Company for the purposes of being able to offer more plan and premium options to employer groups under an HMO structure.

### **PURPOSE AND SCOPE**

A state market conduct examiner with the Colorado Division of Insurance (“Division”), who was assisted by independent contract examiners, reviewed certain business practices of Humana. This market conduct examination (“MCE”) was conducted in accordance with Colorado insurance laws, §§ 10-1-203, 10-1-204, 10-1-205, as well as §§ 10-3-1106 and 10-16-416, C.R.S., which empower the Commissioner to examine any entity engaged in the business of insurance in the State of Colorado. The findings in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of this examination was to determine Humana’s compliance with Colorado insurance laws related to HMO’s. Examination information contained in this report should serve only this purpose, except as provided by law pursuant to §§ 10-1-204 and 205, C.R.S. The conclusions and findings of this examination will become a public record.

The examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners (“NAIC”). The examiners relied primarily on records and materials maintained and/or supplied by Humana. The market conduct examination covered the period from July 1, 2007, through June 30, 2009.

The examination included review of the following:

- Company Operations and Management
- Marketing
- Complaints
- Producers
- Contract Forms
- New Business Applications and Renewals
- Rating
- Cancellations/Declinations/Non-Renewals
- Claims
- Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for Humana identifying any concerns and/or discrepancies. The comment forms contain a section that permits Humana to submit a written response to the examiners’ comments.

For the period under examination, the examiners included statutory citations and regulatory references related to health insurance laws as they pertained to HMOs. Examination findings may result in administrative action or other action by the Division, as set forth in the Colorado Revised Statutes. (2010). Examiners may not have discovered all unacceptable or non-complying practices of Humana. Failure to identify specific practices of Humana does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance company product.

An error tolerance level of plus or minus ten dollars (\$10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar (\$0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar (\$0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from Humana’s policies, procedures, rules and/or guidelines.

## **METHODOLOGY**

The examiners reviewed Humana’s business practices to determine compliance with Colorado insurance laws. For this examination, special emphasis was given to, but not limited to, the statutes and regulations as shown in Exhibit 1 below.

### **Exhibit 1**

<b>Statute or Regulation</b>	<b>Subject</b>
Section 10-1-128, C.R.S.	Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration.
Section 10-2-401, C.R.S.	License required.
Section 10-2-702, C.R.S.	Commissions.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-103.5, C.R.S.	Payment of premiums – required term in contract.
Section 10-16-104, C.R.S.	Mandatory coverage provisions – definitions.
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age – coverage for students who take medical leave of absence
Section 10-16-105, C.R.S.	Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic health benefit plans - rules - benefit design advisory committee - repeal.
Section 10-16-105.2, C.R.S.	Small employer health insurance availability program.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-107, C.R.S.	Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – loss ration guarantees – disclosures on treatment of intractable pain.
Section 10-16-107.2, C.R.S.	Filing of health policies.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-109, C.R.S.	Rules and regulations.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – internal review - rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-201.5, C.R.S.	Renewability of health benefit plans – modifications of health benefit plans.
Section 10-16-401, C.R.S.	Establishment of health maintenance organizations.
Section 10-16-403, C.R.S.	Powers of health maintenance organizations - repeal.
Section 10-16-407, C.R.S.	Information to enrollees.
Section 10-16-409, C.R.S.	Complaint System
Section 10-16-413, C.R.S.	Prohibited practices.
Section 10-16-416, C.R.S.	Examination.
Section 10-16-421, C.R.S.	Statutory construction and relationship to other laws.
Section 10-16-423, C.R.S.	Confidentiality of health information.
Section 10-16-427, C.R.S.	Contractual relations.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile

	with Individually-owned Private Passenger Automobile-Type Endorsement Forms, Claims-made Liability Forms and Preneed Funeral Contracts
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties and Timelines Concerning Division Inquiries and Document Requests
Insurance Regulation 4-2-5	General Hospital Definition
Insurance Regulation 4-2-11	Rate Filing And Annual Report Submissions Health Insurance
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions
Insurance Regulation 4-2-20	Concerning the Colorado Comprehensive Health Benefit Plan Description Form
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-2-24	Concerning Clean Claim Requirements for Health Carriers
Insurance Regulation 4-2-30	Concerning Rules For Complying With Mandated Coverage Of Hearing Aids And Prosthetics
Insurance Regulation 4-6-2	Group Coordination of Benefits
Insurance Regulation 4-6-3	Concerning CoverColorado Standardized Notice Form and Eligibility Requirements
Insurance Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Emergency Regulation 08-E-12 (1-1-09)	Concerning Small Employer Group Health Benefit Plans and The Basic And Standard Health Benefit Plans
Insurance Regulation 4-6-5 (2-1-09)	Concerning Small Employer Group Health Benefit Plans and The Basic And Standard Health Benefit Plans
Insurance Regulation 4-6-9	Conversion Coverage
Insurance Regulation 4-7-1	Health Maintenance Organizations
Insurance Regulation 4-7-2	Health Maintenance Organization Benefit Contracts and Services in Colorado
Insurance Regulation 6-2-1	Complaint Records Maintenance

### **Prior Examinations**

This is the initial examination of this Company conducted by the Colorado Division of Insurance.

### **Sampling Methodology**

In accordance with the sampling methodology and sample sizes set forth in the 2010 NAIC Market Regulation Handbook ("Handbook"), the examiners reviewed the files that were randomly selected to constitute the sample base from a larger population of files.

Where the error rates of the samples indicated it would be appropriate to select an additional sample per the sampling instructions in the Handbook, but the initial results were conclusive, Humana was afforded the opportunity to agree that the initial sample was appropriate or request that an additional sample be selected. In each of these instances, Humana indicated that the initial sample was appropriate.

When sampling was involved, a minimum error tolerance level of seven percent (7%) for claims, or ten

percent (10%) for other samples, was established to determine reportable exceptions. However, if an issue was determined to be systemic, or when the sampling process precluded establishment of an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate higher than the minimum tolerance level, the results of any other samples in that particular area, with exception percentages less than the minimum tolerance threshold, were also included.

### **Company Operations and Management**

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, claims and underwriting guidelines/procedures, and timely cooperation with the examination process.

### **Producers**

The examiners reviewed the licensing status of the submitting producers for the samples of the files selected in the new business applications section of the examination for compliance with the appropriate Colorado statutes and regulations.

### **Complaints**

A review was performed on complaints received by Humana and the Division and traced into Humana's complaint records to verify accuracy in maintaining complaint records.

### **Marketing**

The examiners reviewed various advertising and marketing material for compliance with Colorado insurance law.

### **Contract Forms**

The examiners reviewed the following forms:

- Humana Co-payment Schedules, Evidences of Coverage and Schedule of Benefits, and Prescription Drug Riders;
- Humana's most commonly sold group contracts that are marketed to small groups;
- Humana's conversion contracts, application form, definitions, eligibility, and termination provisions; and
- Humana's group and employee applications/enrollment forms and supporting documents.

These forms were issued and included on the annual certified listing filed with the Division for the period under review.

### **New Business Applications and Renewals**

For the period July 1, 2007 to June 30, 2009 the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- A random sample of seventy-nine (79) approved small employer group new business application files; and

- A random sample of 113 of the total population of 687 renewed large group files.

### **Rating**

The examiners reviewed and rated premium rates charged in the sample files selected in the new business applications and renewals aspect of the examination. These rates were reviewed for compliance with the rate filings submitted to the Division as the rates being used during the examination period as well as for compliance with the appropriate statutes and regulations.

### **Cancellations/Declinations/Non-Renewals/Rescissions**

The examiners reviewed a sample of seventy-nine (79) cancelled or non-renewed files from a population of 108 for compliance with statutory requirements and contractual obligations. Humana reports no declined applications for the period under review. There were no rescissions during the examination period.

### **Claims**

In order to determine Humana's compliance with Colorado's prompt payment of claims law as well as the proper and accurate payment of claims, the examiners reviewed the following random samples:

- One hundred nine (109) paid claim files for accuracy of processing;
- One hundred nine (109) denied claim files for accuracy of processing;
- One hundred five (105) electronically received paid claim files processed in greater than thirty (30) days;
- Eighty-two (82) non-electronically received paid claims files processed in greater than forty-five (45) days; and
- Seventy-six (76) paid claim files processed in greater than ninety (90) days.

### **Utilization Review**

The examiners reviewed Humana's utilization management program including policies and procedures. The review included Humana's overall utilization review handling practices, as well as timeliness of completing the review, communication of the decisions to the appropriate persons and the proper credentials of clinical peers in order to determine compliance with Colorado insurance law.

The examiners selected for review the following random samples from the total of 5,063 utilization review decisions conducted during the examination period:

#### **Standard Utilization Review Determinations**

- Approved: 115 from a population of 4,103
- Denied: 113 from a population of 794

### **Appeals**

- First Level: The total population of fifty five (55)
- Second Level: Humana reported no Second Level Appeals (0)
- External: The total population of three (3)

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**EXAMINATION REPORT SUMMARY**

The examination resulted in a total of thirty-five (35) findings in which Humana did not appear to be in compliance with Colorado statutes and regulations. The following is a summary of the examiners' findings.

**Operations and Management:** There were four (4) areas of concern identified by the examiners in their review of Humana's Operations and Management:

**Issue A1: Failure, in some instances, to maintain records required for market conduct purposes.**

**Issue A2: Failure to maintain an Access Plan as required by Colorado insurance law.**

**Issue A3: Failure to annually provide required information to enrollees regarding the financial condition and any organizational changes to the health maintenance organizations.**

**Issue A4: Failure, in some instances, to properly certify policy forms and use of non-compliant forms.**

**Complaints:** There was one (1) area of concern identified by the examiners in the review of Humana's complaints:

**Issue C1: Failure to maintain a complete record of all the complaints received by Humana during the period under examination..**

**Contract Forms:** There were twenty-one (21) areas of concern identified by the examiners in their review of Humana's Contract Forms.

**Issue E1: Failure, in some instances, to include the mandated benefit of hearing aids for minor children.**

**Issue E2: Failure to provide reimbursement for covered services when lawfully performed by a licensed provider who is a family member.**

**Issue E3: Failure to reflect correct/complete coverage for home health services and hospice care.**

**Issue E4: Failure, in some instances, to reflect correct conditions under which coverage is to be provided for services received in an emergency room.**

**Issue E5: Failure, in some instances, to reflect completely the coverage to be provided for organ transplants.**

**Issue E6: Failure, in some instances, to reflect the correct or complete coverage to be provided for a newborn.**

**Issue E7: Failure, in some instances, to provide correct or complete Child Health Supervision Services.**

**Issue E8: Failure, in some instances, to reflect correct or complete utilization review procedures.**

**Issue E9: Failure to reflect all required information on the complaint forms to be given to enrollees who wish to register written complaints.**

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**Issue E10:** Failure, in some instances, to reflect the correct upper age limit for medically necessary therapy for Congenital Defects and Birth Abnormalities to be provided.

**Issue E11:** Failure, in some instances, to reflect the required coverage for mammography.

**Issue E12:** Failure, in some instances, to reflect correct or complete benefits for prostate cancer screenings.

**Issue E13:** Failure, in some instances, to reflect the mandated benefit for cervical cancer vaccination.

**Issue E14:** Failure, in some instances, to provide for replacement or repair of prosthetic devices.

**Issue E15:** Failure to allow coverage to continue for an insured based solely on that individual's membership in the uniformed services of the United States.

**Issue E16:** Failure, in some instances, to reflect correct or complete Grievance and Appeal Procedures.

**Issue E17:** Failure, in some instances, to reflect the correct information concerning payment of premium for a newborn.

**Issue E18:** Failure to reflect that coverage is to be provided for urgent, non-routine after hours care for out-of-network services if an insured is temporarily traveling out of the service area.

**Issue E19:** Failure, in some instances, to allow coverage for transportation associated with hospice care.

**Issue E20:** Failure, in some instances, to reflect the mandated early intervention services to be provided as of January 1, 2008.

**Issue E21:** Failure to reflect correct information as to which Colorado counties have no participating providers.

**Rating:** In the area of rating, no compliance issues are addressed in this report.

**New Business Applications and Renewals:** In the area of new business applications and renewals there were two (2) areas of concern addressed in this report:

**Issue G1:** Use of a group policy issued to the Employers Health Insurance Benefit Trust, a non-approved Trust, to offer conversion plans to eligible individuals.

**Issue G2:** Failure to ensure that there are no restrictive underwriting practices and standards for small employer groups.

**Cancellations/Non-Renewals/Declinations:** There were two (2) areas of concern identified during the review of the cancellation, non-renewal and declination files.

**Issue H1:** Failure to reflect a definition of "Significant break in coverage" on Certificates of Creditable Coverage.

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**Issue H2: Failure, in some instances, to offer each member of a terminating group a choice of the Basic or Standard Health Benefit plan.**

**Claims:** The examiners identified one (1) area of concern in their review of the claims handling practices of Humana:

**Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.**

**Utilization Review:** The examiners identified four (4) areas of concern in their review of Humana's Utilization Review procedures:

**Issue K1: Failure, in some instances, to include a consultation with an appropriate clinical peer when evaluating first level review appeals.**

**Issue K2: Failure, in some instances, to notify and issue a First Level Appeal decision no later than thirty (30) days after receipt of the grievance requesting the first level review.**

**Issue K3: Failure, in some instances, to have written denials of requests for benefits as not medically necessary, appropriate, effective, or efficient signed by a licensed physician.**

**Issue K4: Failure to include correct information regarding preauthorization in utilization review approval letters.**

**FACTUAL FINDINGS**

**HUMANA HEALTH PLAN, INC.**

**COMPANY OPERATIONS AND MANAGEMENT**

**Issue A1: Failure, in some instances, to maintain records required for market conduct purposes.**

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of § 10-1-109(1), C.R.S., states in part:

...

**Section 4. Records Required For Market Conduct Purposes**

*A. Every entity subject to the Market Conduct process shall maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations, including but not limited to, company operations and management, policyholder services, claim's practices, rating, underwriting, marketing, complaint/grievance handling, producer licensing records, and additionally for health insurers/carriers or related entities: network adequacy, utilization review, quality assessment and improvement, and provider credentialing. Records for this regulation regarding market conduct purposes shall be maintained for the current calendar year plus two prior calendar years. [Emphasis added.]*

The examiners requested a sample of Certificates of Creditable Coverage for Small Groups that had cancelled during the period under examination. Humana is not in compliance with Colorado insurance law in that it could not produce the requested Certificates of Creditable Coverage for small groups, and therefore no verification of information contained in the Certificates could be performed. Humana could produce only the name of the insured and a run date of when the Certificate was produced, but no other information was available. Instead of the actual Certificate of Creditable Coverage provided for each individual in the sample, Humana provided a template with generic information.

The incidence of error for Certificates of Creditable Coverage is as follows:

**Certificates of Creditable Coverage  
July 1, 2007-June 30, 2009**

<b>Population</b>	<b>Sample</b>	<b>Incidence of Error</b>	<b>Percentage to Sample</b>
108	79	79	100%

In addition, the examiners requested the notices for cancellations for non-payment of premium for small groups that had cancelled during the period under examination. Humana is not in compliance with Colorado insurance law in that it could not produce the requested Notice of Cancellation for Non-payment of Premium for small groups, and therefore no verification of information contained in these notices could be performed. Humana could produce only the name of the insured group and a run date of when the notice was produced, but no other information was available. Instead of the actual cancellation notice, Humana provided a template with generic information.

**Small Group Notice of Cancellation for Nonpayment of Premium  
July 1, 2007-June 30, 2009**

<b>Population</b>	<b>Sample Size</b>	<b>Number of Exceptions</b>	<b>Total Error Rate</b>
108	79	79	100%

**Recommendation No. 1:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 1-1-7, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has revised its policies and procedures to ensure that all future records required for market conduct purposes are retained and can be provided within and for the required time period as is mandated by Colorado insurance law.

<b>Issue A2: Failure to maintain an Access Plan as required by Colorado insurance law.</b>
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Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration – repeal, states in part:

. . .

- (9) Beginning January 1, 1998, *a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204 (3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan. All rights and responsibilities of the covered person under the health benefit plan, however, shall be included in the contract provisions, regardless of whether or not such provisions are also specified in the access plan. The carrier shall prepare an access plan prior to offering a new managed care network and shall update an existing access plan whenever the carrier makes any material change to an existing managed care network, but not less than annually. . . .*

Humana is not in compliance with Colorado insurance law in that it could not provide any document meeting the requirements/definition of an Access Plan that is to be maintained for each managed care network that the carrier offers in the state.

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**Recommendation No. 2:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-704, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has developed a written access plan for each managed care network offered in Colorado and has established written procedures to ensure ongoing compliance with Colorado insurance law in maintaining and making available an access plan for each managed care network offered in Colorado.

<b>Issue A3: Failure to annually provide required information to enrollees regarding the financial condition and any organizational changes to the health maintenance organizations.</b>
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Section 10-16-407, C.R.S., Information to enrollees, states in part:

- (1) Every health maintenance organization shall annually provide to its enrollees:
  - (a) *The most recent annual statement of financial condition including a balance sheet and summary of receipts and disbursements; [Emphasis added.]*
  - (b) *A description of the organizational structure and operation of the health care plan and a summary of any material changes since the issuance of the last report; [Emphasis added.]*

Humana is not in compliance with Colorado insurance law in that the two (2) items, (reflected below) are to be provided annually to enrollees, and were not provided for calendar years 2008 and 2009:

- (1) The most recent annual statement of financial condition including a balance sheet and summary of receipts and disbursements and
- (2) A description of the organizational structure and operation of the health care plan and a summary of any material changes since the issuance of the last report.

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**Recommendation No. 3:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-407, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has established procedures to ensure compliance with Colorado insurance law in that all information required to be provided annually to enrollees shall be provided commencing in calendar year 2011.

<b>Issue A4: Failure, in some instances, to properly certify policy forms and use of non-compliant forms.</b>
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Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

- (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

...

- (s) Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

An officer of Humana must certify compliance with Colorado insurance law with all initial filings of policy forms and on the annual report of policy forms. Humana is not in compliance with Colorado insurance law in that not all forms that were certified and used by Humana in 2008 and 2009 were in compliance with statutory requirements as evidenced by Issues #E1 through #E21.

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**Recommendation No. 4:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has implemented procedures to ensure that all applicable forms to be issued or delivered to Colorado insureds comply with statutory mandates through certification by an officer of Humana, and as required by Colorado insurance law.

<p><b><u>COMPLAINTS</u></b></p>
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<b>Issue C1: Failure to maintain a complete record of all the complaints received by Humana during the period under examination.</b>
--

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

- (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
  - ...
  - (i) Failure to maintain complaint handling procedures: *Failing of any insurer to maintain a complete record of all the complaints which it has received since the date of its last examination.* This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this paragraph (i), “complaint” shall mean any written communication primarily expressing a grievance. [Emphasis added.]

Section 10-16-409, C.R.S., Complaint system, states in part:

- ...
- (1)(b) Each health maintenance organization shall maintain in a form prescribed by the commissioner after consultation with the executive director, for examination by the commissioner or the executive director, which shall include:
  - (I) A description of the procedures of such complaint system;
  - (II) *The total number of complaints handled through such complaint system and a compilation of causes underlying the complaints filed.* [Emphasis added.]

Colorado Insurance Regulation: 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, C.R.S., states in part:

...

Section 10      First Level Review

...

- C. Pursuant to Section 10-3-1104(1)(i), C.R.S., *all written requests for a first level review must be entered into the carrier’s complaint record.* [Emphasis added.]

Colorado Insurance Regulation 4-7-1, Health Maintenance Organizations, promulgated under the authority of §§ 10-16-109, 10-16-401(4)(o); and 10-16-403(2)(b), C.R.S., states in part:

...

#### Section 16      Complaint Records

Pursuant to § 10-16-409, C.R.S., a complaint system is to be maintained by an HMO. As part of the complaint system, an HMO shall maintain a Complaint Record Maintenance which has the information required in Colorado Insurance Regulation 6-2-1, (3CCR 702-6) and information regarding malpractice claims as required by § 10-16-409(1)(b)(III), C.R.S.

Colorado Insurance Regulation 6-2-1, Complaint Record Maintenance, promulgated under the authority of § 10-3-1110, C.R.S., states in part:

...

#### V. Maintenance of Record

The complaint record shall be kept on a calendar year basis and the number of complaints by line of insurance, function, reason, disposition, and state of origin shall be compiled not less frequently than annually.

Humana provided a population of fifty-four (54) Colorado Utilization Review First Level Appeal files for review. Humana is not in compliance with Colorado insurance law in that fifty-one (51) of these fifty-four (54) requests for a first level review were written requests and were not recorded on the complaint log as required.

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#### **Recommendation No. 5:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 and 10-16-409, C.R.S. and Colorado Insurance Regulations 4-2-17, 4-7-1 and 6-2-1, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to such documentation, it shall provide written evidence to the Division of Insurance that it has established procedures to ensure that all future consumer complaints as defined by Colorado insurance law are recorded on the complaint records maintained by Humana.

**CONTRACT FORMS**

<b>Issue E1: Failure, in some instances, to include the mandated benefit of hearing aids for minor children.</b>
--

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

...

(19) Hearing aids for children – legislative declaration.

- (a) The general assembly hereby finds and determines that the language development of children with partial or total hearing loss may be impaired due to the hearing loss. Children learn the concept of spoken language through auditory stimuli, and the language skills of children who have hearing loss improve when they are provided with hearing aids and access to visual language upon the discovery of hearing loss. The general assembly therefore declares that providing hearing aids to children with hearing loss will reduce the costs borne by the state, including special education, alternative treatments that would otherwise be necessary if a hearing aid were not provided, and other costs associated with such hearing loss.
- (b) *Any health benefit plan that provides hospital, surgical, or medical expense insurance, except supplemental policies covering a specified disease or other limited benefit, shall provide coverage for hearing aids for minor children who have a hearing loss that has been verified by a physician licensed pursuant to article 36 of title 12, C.R.S., and by an audiologist licensed pursuant to section 12-5.5-102, C.R.S. The hearing aids shall be medically appropriate to meet the needs of the child according to accepted professional standards. Coverage shall include the purchase of the following: [Emphasis added.]*
  - (I) Initial hearing aids and replacement hearing aids not more frequently than every five years;
  - (II) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child;
  - (III) Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.
- (c) The benefits accorded pursuant to this subsection (19) shall be subject to the same annual deductible or copayment established for all other covered benefits within the insured's policy and utilization review as provided in sections 10-16-112, 10-16-113, and 10-16-113.5. The benefits shall also be subject to part 7 of this article.
- (d) Health benefit plans issued by an entity subject to this part 1 may provide that the benefits required pursuant to this section shall be covered benefits only if the services are deemed medically necessary.

Colorado Insurance Regulation 4-2-30, Concerning The Rules for Complying with Mandated Coverage of Hearing Aids and Prosthetics, promulgated under the authority of § 10-1-109, C.R.S., states in part:

...

**Section 3    Applicability**

This regulation applies to all individual and group health benefit plans issued or renewed on or after January 1, 2009 by entities subject to Part 2, Part 3 and Part 4 of Article 16 of Title 10 of the Colorado Revised Statutes.

**Section 4    Definitions**

...

- C. “Hearing aid” shall have the same meaning as set forth in § 10-16-102(24.7), C.R.S.

...

- E. “Minor child” shall have the same meaning as set forth in § 10-16-102(27.3), C.R.S.

**Section 5    Rules**

**A. Hearing aids.**

1. For the purposes of § 10-16-104(19), C.R.S., hearing aids do not meet the traditional definition of durable medical equipment; therefore, *any benefits paid for a minor child’s hearing aid(s) in accordance with the coverage mandated by Colorado law shall not be used to exhaust a health benefit plan’s annual or lifetime durable medical equipment maximum, if any.* [Emphasis added.]
2. *The mandated coverage of hearing aids for a minor child shall be provided subject to the same annual deductible and/or copayment/coinsurance levels established for other covered benefits.* Benefits shall be determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). These benefits are subject to the policy’s general annual and/or lifetime maximum benefit amounts. Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S. [Emphasis added.]
3. *The coverage includes the initial assessment, fitting, adjustments, and the required auditory training.* Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. This requirement shall apply to each hearing aid if the minor child has two hearing aids. [Emphasis added.]

Emergency Regulation 08-E-12, (effective November 8, 2008, with benefits effective January 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

Section 7 Effective Date

This emergency regulation is effective on November 8, 2008.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS  
FOR THE STATE OF COLORADO

Colorado Division of Insurance

Effective January 1, 2009

*(3) All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.*

All other provisions of Title 10 which apply to group sickness and accident insurers, nonprofit health and hospital service corporations, and health maintenance organizations, *and all rules and regulations related to those provisions, as they relate to small employer group plans, shall also apply.* [Emphases added.]

Benefit Grid

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

...

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC HMO PLAN
<b>31. SIGNIFICANT ADDITIONAL SERVICES</b> (List up to 5) <b>a) Hearing Aids</b> <sup>19a</sup>	<b>Benefit level determined by place of service</b>

- 19a As of January 1, 2009, hearing aids for dependent children under the age of 18 are covered in compliance with § 10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined

by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

	<b>STANDARD HMO PLAN</b>
<b>31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)</b> <b>a) Hearing Aids <sup>23a</sup></b>	<b>Benefit level determined by place of service</b>

23a As of January 1, 2009, hearing aids for dependent children under the age of 18 are covered in compliance with § 10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

Colorado Insurance Regulation 4-6-5, (amended February 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

**BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS  
FOR THE STATE OF COLORADO**

Colorado Division of Insurance

Effective February 1, 2009

*(3) All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.*

All other provisions of Title 10 which apply to group sickness and accident insurers, nonprofit health and hospital service corporations, and health maintenance organizations, *and all rules and regulations related to those provisions, as they relate to small employer group plans, shall also apply.* [Emphases added.]

Benefit Grid

**PART B: SUMMARY OF BENEFITS**

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

...

<b>BASIC LIMITED MANDATE HEALTH BENEFIT PLAN</b>	<b>BASIC HMO PLAN</b>
<b>31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5) a) Hearing Aids <sup>19a</sup></b>	<b>Benefit level determined by place of service</b>

- 19a As of January 1, 2009, hearing aids for dependent children under the age of 18 are covered in compliance with § 10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

	<b>STANDARD HMO PLAN</b>
<b>31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5) a) Hearing Aids <sup>23a</sup></b>	<b>Benefit level determined by place of service</b>

- 23a As of January 1, 2009, hearing aids for dependent children under the age of 18 are covered in compliance with § 10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

Humana was not in compliance with Colorado insurance law for the period of January 1, 2009 through July 22, 2009 as the Basic and Standard plans and the three (3) National POS plans reflected an exclusion for “hearing aids” which is a mandated coverage for a minor child. This mandated benefit became effective January 1, 2009 and the exclusion does not appear to have been corrected in the plans until July 23, 2009 when updated language was introduced.

Page 44 of the Basic HMO Limited Mandate plan,  
Page 48 of the Standard HMO plan,  
Page 194 of the National CovFirst plan and  
Page 184 of the National HDHP plan reflect:

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## LIMITATIONS AND EXCLUSIONS

### Limitations and exclusions

Unless specifically stated otherwise, no benefits will be provided for or on account of the following items:

- Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices.

Page 55 of the National POS plan reflects:

- Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices, except for cochlear implants as otherwise stated in this *certificate*.

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National POS Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

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### **Recommendation No. 6:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulations 4-2-30, Emergency Regulation 08-E-12 and 4-6-5, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has established procedures to ensure that all applicable forms have been corrected to reflect the mandated coverage for hearing aids for minor children as required by Colorado insurance law, inclusive of those provisions set forth above.

<b>Issue E2: Failure to provide reimbursement for covered services when lawfully performed by a licensed provider who is a family member.</b>
---

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

...

(7) Reimbursement of providers.

(a) Sickness and accident insurance.

(I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, *whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed.* . . . [Emphasis added.]

Humana's Basic and Standard plans and its small group plans reviewed were not in compliance with Colorado insurance law in that they exclude coverage for services performed by a provider who is a member of the covered person's family. A policy may contain an exclusion for charges that would not be billed if the member did not have insurance, but the policy may not exclude reimbursement for covered services performed by a licensed provider if the provider normally charges for the services; nor can a policy deny reimbursement for covered benefits based solely upon the provider's status, (e.g., a family member).

Page 44 of the Basic HMO Limited Benefit plan,  
Page 48 of the Standard HMO plan,  
Page 57 of the National HDHP plan,  
Page 54 of the National POS plan and  
Page 62 of the National CovFirst plan reflect:

## **LIMITATIONS AND EXCLUSIONS**

### **Limitations and exclusions**

Unless specifically stated otherwise, no benefits will be provided for or on account of the following items:

- Medical services provided by a *covered person's family member*.

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<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National POS Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

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**Recommendation No. 7:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has revised all applicable forms to remove the exclusion for reimbursing licensed providers who are family members as required by Colorado insurance law.

**Issue E3: Failure to reflect correct/complete coverage for home health services and hospice care.**

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

...

(8) Availability of hospice care coverage.

(a) As used in this subsection (8), unless the context otherwise requires:

(I) “Home health services” means home health services as defined in section 25.5-4-103(7), C.R.S., which are provided by a home health agency certified by the department of public health and environment.

(II) “Hospice care” means hospice services provided to a terminally ill individual by a hospice care program, licensed and regulated by the department of public health and environment pursuant to sections 25-1.5-103(1)(a)(I) and 25-3-101, C.R.S., or by others under arrangements made by such hospice care program.

(b) Notwithstanding any other provision of the law to the contrary, no individual or group policy of sickness and accident insurance issued by an insurer subject to the provisions of part 2 of this article and no plan issued by an entity subject to the provisions of part 3 of this article which provides hospital, surgical, or major medical coverage on an expense incurred basis shall be sold in this state unless a policyholder under such policy or plan is offered the opportunity to purchase coverage for benefits for the costs of home health services and hospice care which have been recommended by a physician as medically necessary. Nothing in this paragraph (b) shall require an insurer to offer coverages for which premiums would not cover expected benefits. This paragraph (b) shall not apply to any insurance policy, plan, contract, or certificate which provides coverage exclusively for disability loss of income, dental services, optical services, hospital confinement indemnity, accident only, or prescription drug services.

...

(d) The commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions *which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care*. Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphasis added.]

Colorado Insurance Regulation 4-2-8, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of §§ 10-1-109 and 10-16-104(8)(d), C.R.S., states in part:

Section 4 Requirements for Home Health Services

A. Definitions.

...

- (2) "Home health services" means the following services provided by a certified home health agency under a plan of care to eligible persons in their residence:

...

- (d) Physical therapy, occupational therapy or speech pathology *and audiology* services, such as therapy and services are defined C.R.S. [Emphasis added.]

- (3) "Home health visit" is each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. Services of up to *4 hours by a home health aide shall* be considered as one visit. [Emphasis added.]

B. General Policy Provisions Pertaining to Home Health Care.

- (1) The policy offering *shall provide that* home health services are to be covered when such services are necessary as alternatives to hospitalization or in place of hospitalization. *Prior hospitalization shall not be required.* [Emphases added.]

C. Benefits for Home Health Care Services.

...

- (3) The policy offered shall include benefits for the following services:

...

- (e) Speech therapy and *audiology*; [Emphasis added.]

- (f) Respiratory and *inhalation* therapy; [Emphasis added.]

Section 5 Requirements for Hospice Care

A. Definitions.

...

- (3) A "*patient*" is an individual in the terminal stage of illness who *has an anticipated life expectancy of six months or less* and who alone or in conjunction with a family member or members, has voluntarily requested admission and been accepted into a hospice. [Emphases added.]
- (4) A "*patient/family*" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, *the primary care giver and individuals with significant personal ties.* [Emphasis added.]

...

- (12) "Home care services" are hospice services, which are provided in the place the *patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.* [Emphases added.]

...

- (15) "Hospice Levels of Care."

...

- (c) "Inpatient hospice respite care:" The level of care received when the patient is in a licensed facility *to provide the caregiver a period of relief. Inpatient respite care* may be provided only on an intermittent, non- routine, short-term basis. It may be limited to periods of five days or less. [Emphasis added]

...

- (18) A "*benefit period*" for hospice care services *is a period of three months, during which services are provided on a regular basis.* [Emphases added.]

...

- (20) An "*unrelated illness*" is a diagnosed condition, which is not a direct result of the terminal diagnosis or its treatment and the expected course of that terminal illness. [Emphasis added]

B. General Provisions Pertaining to Hospice Care.

...

- (2) The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, except that benefits may exceed six months *should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. After the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.* [Emphasis added]

...

- (5) The policy offering shall *clearly indicate* that services and charges incurred *in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable* to all other illnesses and/or injuries. [Emphasis added]

C. Benefits for Hospice Care Services.

...

- (2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. *Any policy offered shall provide a benefit of no less than \$100 per day for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team:* [Emphasis added.]

- (a) Intermittent and 24 hour on-call professional nursing services provided by or under the supervision of a Registered Nurse;
- (b) Intermittent and 24 hour on-call social/counseling services: and;
- (c) Certified nurse aide services or nursing services delegated to other persons pursuant to § 12-38-132, C.R.S.

*The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days.* [Emphasis added.]

- (3) The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and *shall not be included in the dollar limitation for hospice care benefits a specified in (2) above.*

...

- (i) *Transportation;* [Emphases added.]

Humana's Basic and Standard HMO and small group plans reviewed are not in compliance with Colorado insurance law in that they do not express correctly the extent of coverage to be provided for home health services in the following ways:

HOME HEALTH SERVICES

Incorrect

- A limitation for Home Health Care Services is reflected that is more limited than allowed by Colorado insurance law. Services up to four (4) hours by a home health aide shall be considered as one visit, the certificate incorrectly reflects two (2) hours or less as one visit.

Humana's Basic & Standard and small group plans reviewed did not express completely the extent of coverage to be provided for home health services in the following ways:

HOME HEALTH SERVICES

Incomplete:

- None of the plans reviewed reflected the provision that prior hospitalization is not required.

- The Basic and Standard plans reviewed do not reflect the fact that audiology and inhalation therapy are home health services for which benefits are provided.
- None of the plans reviewed reflect the provision that “Home care services” are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.
- Additionally, the Small Group and Basic and Standard certificates define “Home health care plan” as a plan of care and treatment to be provided in the home.

### HOSPICE CARE

#### Incomplete

- The Basic and Standard and small group plans reviewed do not indicate that a “benefit period” for hospice care services is a period of three (3) months, during which services are provided on a regular basis or that three benefit periods may be provided if needed with a benefit not less than the per diem (\$100) benefit multiplied by ninety-one (91) days.
- The Basic and Standard and small group plans reviewed do not reflect that in the event the patient lives beyond the prognosis for life expectancy, the insurer’s case management staff will work with the patient’s attending physician and the hospice director to determine the appropriateness of continuing hospice care.
- The Basic and Standard and small group plans reviewed do not indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.
- The certificates for the Basic and Standard and small group plans reviewed provide an incomplete definition for “family member” in that there is no provision in the certificates for hospice care benefits, which includes the “primary care giver and individuals with significant personal ties” in addition to the immediate “family members.” Additionally, the Basic and Standard plans include an exclusion for Bereavement counseling services for “family members” not covered under the plan. Individuals other than a spouse, child, brother, sister or parent would be entitled to bereavement support services.
- Nothing is reflected in the Basic and Standard or small group plans under review concerning the “inpatient hospice respite care,” one of the hospice levels of care that is to be covered when provided on an intermittent, non-routine, short-term basis and that may be limited to periods of five days or less.
- Transportation, one of the benefits required to be provided as a hospice care service, is not reflected in the Hospice Care benefit section of the Basic and Standard plans being reviewed, and is reflected as being specifically excluded in the Limitations and Exclusions section.

Page 34 of the Basic HMO Limited Mandate plan,  
Page 36 of the Standard HMO plan,  
Page 43 of the National HDHP plan,  
Page 40 of the National POS plan and  
Page 48 of the National CovFirst plan reflect:

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COVERED EXPENSES

Home health care

The “Schedule of Benefits” shows the maximum number of visits allowed by a representative of a *home health care agency*, if any. A visit by any representative of a *home health care agency* of ***two hours or less will be counted as one visit.***

Page 34 of the Basic HMO Limited Mandate plan and  
Page 36 of the Standard HMO plan reflect:

Home health care

Home health care *covered expenses* include:

- Care provided by a *nurse*;
- Physical, occupational, respiratory or speech therapy, medical social work and nutrition services; and
- Medical appliances, equipment and laboratory services.

Page 93 of the Basic HMO Limited Mandate plan,  
Page 97 of the Standard HMO plan,  
Page 110 of the National HDHP plan,  
Page 105 of the National POS plan and  
Page 115 of the National CovFirst plan reflect:

GLOSSARY

***Home health care plan*** means a plan of care and treatment for *you* to be provided *in your home*.  
[Emphasis added.]

Page 91 of the Basic HMO Limited Mandate plan,  
Page 95 of the Standard HMO plan,  
Page 108 of the National HDHP plan,  
Page 104 of the National POS plan and  
Page 113 of the National CovFirst plan reflect:

GLOSSARY

**Family member** means *you or your spouse, or your or your spouse’s child, brother, sister, or parent.* [Emphasis added.]

Page 35 of the Basic HMO Limited Mandate plan, Page 37 of the Standard HMO plan reflect:

COVERED EXPENSES

We will pay benefits for *covered expenses* incurred by you for a hospice care program.

...

If the above criteria is not met, no benefits will be payable under the *master group contract*.

Hospice

- Counseling for the terminally ill covered person and his/her immediate covered *family members* by Clinical social worker; or Pastoral counselor during the twelve-month period following death. The maximum benefit payable for this service is \$1150.

Hospice care *covered expenses* do not include:

- Bereavement counseling services for family members not covered under this *master group contract*.

Page 44 of the National HDHP plan, Page 41 of the National POS plan and Page 49 of the National CovFirst plan reflect:

COVERED EXPENSES

Hospice

We will pay benefits for *covered expenses* incurred by you for a hospice care program.

If the above criteria is not met, no benefits will be payable under the *master group contract*.

Hospice care benefits are payable as shown on the “Schedule of Benefits” for the following hospice services, subject to the *individual lifetime maximum benefit* and any other maximum(s):

- Bereavement support services *for the hospice patient’s family* during the twelve month period following death. The maximum benefit payable for this service is \$1,150. [Emphasis added.]

Page 47 of the Basic HMO Limited Mandate plan, Page 51 of the Standard HMO plan reflect:

LIMITATIONS AND EXCLUSIONS (continued)

Unless specifically stated otherwise, no benefits will be provided for or on account of the following items:

- Lodging accommodations or *transportation*.

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National POS Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

**Recommendation No. 8:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-2-8, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has revised all applicable forms to reflect correct and complete provisions for home health care and hospice care services as required by Colorado insurance law, inclusive of those provisions set forth above.

**Issue E4: Failure, in some instances, to reflect correct conditions under which coverage is to be provided for services received in an emergency room.**

Section 10-16-407, C.R.S., Information to enrollees, states in part:

...

- (2) ... For the purposes of this section, a “life or limb threatening emergency” means any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. No enrollee shall in any way be discouraged from using the local prehospital emergency medical service system, the 9-1-1 telephone number, or the local equivalent, *or be denied coverage for medical and transportation expenses incurred as a result of such use in a life or limb threatening emergency.* [Emphasis added.]

Colorado Insurance Regulation 4-6-5, (effective January 1, 2008), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

**BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS  
FOR THE STATE OF COLORADO**

Colorado Division of Insurance

- 1 The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables* labeled “*Basic Limited Mandate Health Benefit Plan*”, “*Basic HSA Health Benefit Plan*”, or “*Basic HSA Limited Mandate Health Benefit Plan*”. [Emphasis added.]

Benefit Grid

JANUARY 1, 2008 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay)

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC HMO PLAN
15. EMERGENCY CARE <sup>12, 13</sup>	\$250 copay/visit <sup>14</sup> for in-and out-of-network emergency care.
	STANDARD HMO PLAN
15. EMERGENCY CARE <sup>12, 13</sup>	\$150 copay/visit <sup>14</sup> for in-and out-of-

	network emergency care.
--	-------------------------

- 12 “Emergency care” means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.
- 13 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.
- 14 Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

Emergency Insurance Regulation 08-E-12 (effective November 8, 2008 with benefits effective January 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

**BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS  
FOR THE STATE OF COLORADO**

Colorado Division of Insurance

- 1 The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled “Basic Limited Mandate Health Benefit Plan”, “Basic HSA Health Benefit Plan”, or “Basic HSA Limited Mandate Health Benefit Plan”.* [Emphasis added.]

**Benefit Grid**

**JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:**

**INDEMNITY, PPO AND HMO**

**PART B: SUMMARY OF BENEFITS**

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay)

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC HMO PLAN
15. EMERGENCY CARE <sup>12, 13</sup>	\$250 copay/visit <sup>14</sup> for in-and out-of- network emergency care.

	<b>STANDARD HMO PLAN</b>
<b>15. EMERGENCY CARE</b> <sup>12, 13</sup>	\$150 copay/visit <sup>14</sup> for in-and out-of-network emergency care.

12 “Emergency care” means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

13 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.

14 Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

Colorado Insurance Regulation 4-6-5, (effective February 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

**BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS  
FOR THE STATE OF COLORADO**

Colorado Division of Insurance

1 The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables* labeled “*Basic Limited Mandate Health Benefit Plan*”, “*Basic HSA Health Benefit Plan*”, or “*Basic HSA Limited Mandate Health Benefit Plan*”. [Emphasis added.]

**Benefit Grid**

**FEBRUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:**

**INDEMNITY, PPO AND HMO**

**PART B: SUMMARY OF BENEFITS**

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay)

<b>BASIC LIMITED MANDATE HEALTH BENEFIT PLAN</b>	<b>BASIC HMO PLAN</b>
<b>15. EMERGENCY CARE</b> <sup>12, 13</sup>	\$250 copay/visit <sup>14</sup> for in-and out-of-

	network emergency care.
	STANDARD HMO PLAN
15. EMERGENCY CARE <sup>12, 13</sup>	\$150 copay/visit <sup>14</sup> for in-and out-of-network emergency care.

12 “Emergency care” means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

13 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.

14 Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

Colorado Insurance Regulation 4-7-2, Concerning the Laws Regulating Health Maintenance Organization Benefit Contracts and Services in Colorado, promulgated under the authority of § 10-16-109, C.R.S., states in part:

...

#### Section 4 Definitions

No contract or evidence of coverage delivered or issued for delivery to any person by an HMO required to obtain a certificate of authority in this state shall contain definitions respecting the matters set forth below and in § 10-16-102, C.R.S. unless such definitions comply with the requirements of this section. Definitions other than those set forth herein and in § 10-16-102, C.R.S. may be used as appropriate providing that they do not contradict these requirements. As used in this regulation and for the purpose of any terms used in a benefit contract of evidence of coverage:

...

C. “Emergency services” means health care services provided in connection with any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Humana’s Basic and Standard plans that were reviewed are not in compliance with Colorado insurance law in that they exclude coverage for services received in an emergency room unless required because of an emergency medical condition. This exclusion is more limiting than allowed by Colorado insurance law as:

- (1) A plan must cover this type of care if a prudent lay person would have believed that an emergency medical condition or life or limb threatening emergency existed and

- (2) Non-emergency care delivered in an emergency room only requires that the person receiving such care was referred by his/her carrier or primary care physician.

Page 43 of the Basic HMO Limited Mandate plan,  
Page 47 of the Standard HMO plan,  
Page 58 of the National HDHP plan,  
Page 55 of the National POS plan and  
Page 63 of the National CovFirst plan reflect:

### **LIMITATIONS AND EXCLUSIONS**

Unless specifically stated otherwise, no benefits will be provided for or on account of the following items:

- Services provided to *you*, if *you* do not comply with the *master group contract's* requirements. These include services:
  - Received in an emergency room, unless required because of *emergency care*.

Page 44 of the Basic HMO Limited Mandate plan,  
Page 48 of the Standard HMO plan,  
Page 57 of the National HDHP plan,  
Page 53 of the National POS plan and  
Page 62 of the National CovFirst plan reflect:

- Services received in an emergency room, unless required because of *emergency care*.

This exclusion is also in conflict with the definition of “emergency care” in the plans as:

Page 90 of the Basic HMO Limited Mandate plan,  
Page 94 of the Standard HMO plan,  
Page 231 of the National HDHP plan,  
Page 102 of the National POS plan and  
Page 112 of the National CovFirst plan reflect:

### **GLOSSARY**

**Emergency care** means services provided in a hospital emergency facility for a bodily injury or sickness manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

**Market Conduct Examination  
Contract Forms****Humana Health Plan, Inc.**

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<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National POS Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

---

**Recommendation No. 9:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-407, C.R.S. and Colorado Insurance Regulations 4-6-5, Emergency Regulation 08-E-12 and 4-7-2, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has established procedures to ensure that all applicable forms have been corrected to reflect the correct conditions under which coverage is to be provided for services received in an emergency room as required by Colorado insurance law, inclusive of those provisions set forth above.

**Issue E5: Failure, in some instances, to reflect completely the coverage to be provided for organ transplants.**

Colorado Insurance Regulation 4-6-5, (effective January 1, 2008), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

Section 4 Rules

A. Plans

1. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation* and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and as conversion coverage pursuant to § 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan. [Emphasis added.]

**BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR  
THE STATE OF COLORADO**

Colorado Division of Insurance

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables* labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan". [Emphasis added.]

...

**JANUARY 1, 2008 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT  
PLANS**

**INDEMNITY, PPO AND HMO**

**PART B: SUMMARY OF BENEFITS**

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC HMO PLAN
24. ORGAN TRANSPLANTS <sup>18</sup>	Covered transplants include: liver, <i>heart</i> , heart/lung, lung, cornea, kidney, kidney/pancreas, <i>other single and multi-organ transplants</i> , and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. [Emphasis added.]

18 *Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.* [Emphasis added.]

	STANDARD HMO PLAN
	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, <i>other single and multi-organ transplants</i> , and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. [Emphasis added.]

22 *Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.* [Emphasis added.]

Emergency Insurance Regulation 08-E-12, (effective November 8, 2008, with benefits effective January 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

#### Section 4 Rules

##### B. Plans

2. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and as conversion coverage pursuant to § 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses*

an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan. [Emphasis added.]

**BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR  
THE STATE OF COLORADO**

Colorado Division of Insurance

2. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled “Basic Limited Mandate Health Benefit Plan”, “Basic HSA Health Benefit Plan”, or “Basic HSA Limited Mandate Health Benefit Plan”.* [Emphasis added.]

**JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT  
PLANS**

**INDEMNITY, PPO AND HMO**

**PART B: SUMMARY OF BENEFITS**

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

<b>BASIC LIMITED MANDATE HEALTH BENEFIT PLAN</b>	<b>BASIC HMO PLAN</b>
<b>24. ORGAN TRANSPLANTS</b> <sup>18</sup>	Covered transplants include: liver, <i>heart</i> , heart/lung, lung, cornea, kidney, kidney/pancreas, <i>other single and multi-organ transplants</i> , and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. [Emphasis added.]

18 *Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.* [Emphasis added.]

	<b>STANDARD HMO PLAN</b>
	Covered transplants include: liver, <i>heart</i> , heart/lung, lung, cornea, kidney, kidney/pancreas, <i>other single and multi-organ transplants</i> , and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. [Emphasis added.]

22 *Transplants will be covered only if they are medically necessary and meet clinical*

*standards for the procedure.* [Emphasis added.]

Colorado Insurance Regulation 4-6-5, (effective February 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

Section 4 Rules

C. Plans

3. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation* and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and as conversion coverage pursuant to § 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan. [Emphasis added.]

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR  
THE STATE OF COLORADO

Colorado Division of Insurance

3. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables* labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan". [Emphasis added.]

FEBRUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT  
PLANS

INDEMNITY, PPO AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC HMO PLAN
24. ORGAN TRANSPLANTS <sup>18</sup>	Covered transplants include: liver, <i>heart</i> , heart/lung, lung, cornea, kidney, kidney/pancreas, <i>other single and</i>

	<i>multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. [Emphasis added.]</i>
--	--

18 *Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure. [Emphasis added.]*

	<b>STANDARD HMO PLAN</b>
	Covered transplants include: liver, <i>heart</i> , heart/lung, lung, cornea, kidney, kidney/pancreas, <i>other single and multi-organ transplants</i> , and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. [Emphasis added.]

22 *Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure. [Emphasis added.]*

Humana's Basic and Standard plans are not in compliance with Colorado insurance law in that the coverage reflected for mandated organ transplants is incomplete. Benefits are required to be provided for the heart as a single transplant procedure and also for other single and multi-organ transplants not specifically listed if they are determined to be medically necessary and to meet clinical standards for the procedure.

Page 40 of the Basic HMO Limited Mandate Plan and Page 44 of the Standard HMO plan reflect:

## COVERED EXPENSES – TRANSPLANT SERVICES

### Covered expenses

Covered transplants include: liver, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. *Covered expenses* include charges for peripheral stem cell support for these conditions.

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current

**Recommendation No. 10:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5 and Emergency Regulation 08-E-12, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has established procedures to ensure that all applicable forms have been corrected to reflect the correct conditions under which coverage is to be provided for mandated organ transplant services as required by Colorado insurance law, inclusive of those provisions set forth above.

**Issue E6: Failure, in some instances, to reflect the correct or complete coverage to be provided for a newborn.**

Colorado Insurance Regulation 4-6-5, (effective January 1, 2008), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

**BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR  
THE STATE OF COLORADO**

Colorado Division of Insurance

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and *health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled “Basic Limited Mandate Health Benefit Plan”, “Basic HSA Health Benefit Plan”, or “Basic HSA Limited Mandate Health Benefit Plan”.* [Emphasis added.]

Benefit Grid

JANUARY 1, 2008 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT  
PLANS:

INDEMNITY, PPO AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC HMO PLAN
10. MATERNITY <sup>7</sup>	A one-time \$40 copay for all routine prenatal visits combined; then applicable copays for type of service <sup>8</sup>

	STANDARD HMO PLAN
10. MATERNITY <sup>7</sup>	A one-time \$25 copay for all routine prenatal visits combined; then applicable copays for type of service <sup>8</sup>

<sup>7</sup> Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

<sup>8</sup> The hospital copay applies to mother and well baby together; there are not separate copays.

Attachment 1

Covered Preventive Services <sup>1</sup>	
Age 0 – 12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.

<sup>1</sup> Not all preventative services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account compliant plans).

Emergency Insurance Regulation 08-E-12, (effective November 8, 2008, with benefits effective January 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR  
THE STATE OF COLORADO

Colorado Division of Insurance

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and *health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled “Basic Limited Mandate Health Benefit Plan”, “Basic HSA Health Benefit Plan”, or “Basic HSA Limited Mandate Health Benefit Plan”. [Emphasis added.]*

Benefit Grid

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT  
PLANS:

INDEMNITY, PPO AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC HMO PLAN
10. MATERNITY <sup>7</sup>	A one-time \$40 copay for all routine prenatal visits combined; then applicable copays for type of service <sup>8</sup>

	STANDARD HMO PLAN
10. MATERNITY <sup>7</sup>	A one-time \$25 copay for all routine prenatal visits combined; then applicable copays for type of service <sup>8</sup>

- 7 Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.
- 8 The hospital copay applies to mother and well baby together; there are not separate copays.

Attachment 1

Covered Preventive Services <sup>1</sup>	
Age 0 – 12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.

<sup>1</sup> Not all preventative services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account compliant plans).

Colorado Insurance Regulation 4-6-5, (effective February 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

**BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR  
THE STATE OF COLORADO**

Colorado Division of Insurance

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and *health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled “Basic Limited Mandate Health Benefit Plan”, “Basic HSA Health Benefit Plan”, or “Basic HSA Limited Mandate Health Benefit Plan”.* [Emphasis added.]

Benefit Grid

FEBRUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT  
PLANS:

INDEMNITY, PPO AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC HMO PLAN
10. MATERNITY <sup>7</sup>	A one-time \$40 copay for all routine prenatal visits combined; then applicable copays for type of service <sup>8</sup>

	STANDARD HMO PLAN
10. MATERNITY <sup>7</sup>	A one-time \$25 copay for all routine prenatal visits combined; then applicable copays for type of service <sup>8</sup>

<sup>7</sup> Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

<sup>8</sup> The hospital copay applies to mother and well baby together; there are not separate copays.

Attachment 1

Covered Preventive Services <sup>1</sup>	
Age 0 – 12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.

<sup>1</sup> Not all preventative services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account compliant plans).

Humana's Basic and Standard plans are not in compliance with Colorado insurance law in that the coverage to be provided for newborns is incorrect and incomplete. If the requirements are met for a newborn's home visit as a result of an early discharge, the time frame for the visit is the first week of life. Although under "Health Care Practitioner Office Visits" this is correctly reflected, the plans indicate under "Obstetrical Care and Family Planning" that this mandated coverage for a newborn's home visit must take place within the first forty-eight (48) hours after discharge. Well-baby care is to include an in-hospital newborn hearing screening and this is not reflected.

Page 30 of the Basic HMO Limited Health plan and Page 32 of the Standard HMO plan reflect:

**COVERED EXPENSES**

**Obstetrical care and family planning**

*Covered expenses include:*

- A minimum stay of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 48 hours after discharge is also covered, subject to the terms of this *certificate*.

**Market Conduct Examination  
Contract Forms****Humana Health Plan, Inc.**

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<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current

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**Recommendation No. 11:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5 and Emergency Regulation 08-E-12, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has established procedures to ensure that all applicable forms have been corrected to reflect the correct and complete coverage to be provided for newborns as required by Colorado insurance law, inclusive of those provisions set forth above.

<b>Issue E7: Failure, in some instances, to provide correct or complete Child Health Supervision Services.</b>
--

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

...

- (11) Child health supervision services.
  - (a) For purposes of this subsection (11), unless the context otherwise requires, “*child health supervision services*” means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105 (7.2), to dependent children up to age thirteen. . . . [Emphasis added.]
  - (b) An individual, *small group*, or large group health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, *shall, as to such family member’s coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. Each such plan shall, at a minimum, provide benefits for preventive child health supervision services.* A plan described in this paragraph (b) may provide that child health supervision services rendered during a periodic review shall only be covered to the extent such services are provided during the course of one visit by or under the supervision of a single physician, physician’s assistant, or registered nurse. [Emphasis added.]

Colorado Insurance Regulation 4-6-5, (effective January 1, 2008), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

#### Section 4 Rules

##### A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado’s small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. **Standard Plan.** The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

Attachment 1

<b>Covered Preventive Services <sup>1</sup></b>	
All Children	Immunizations. Immunization deficient children are not bound by "recommended ages".
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery. <i>6 well-child visits <sup>2</sup></i> <i>1 PKU [Emphases added.]</i>
Age 13-35 months	<i>3 well-child visits</i>
Age 3-6	<i>4 well-child visits</i>
Age 7-12	<i>4 well-child visits [Emphases added.]</i>

- 1 Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.
- 2 "Well-child visit" means a visit to a primary care provider that includes the following elements; age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling. The schedule of these visits, through age 12 is based on the recommendations of the American Academy of Pediatrics.

Emergency Insurance Regulation 08-E-12, (effective November 8, 2008, with benefits effective January 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

**Section 4 Rules**

**A. Plans**

1. **Basic Plan.** The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group

market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

Attachment 1

Covered Preventive Services <sup>1</sup>	
All Children	Immunizations. Immunization deficient children are not bound by “recommended ages”.
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery. 6 well-child visits <sup>2</sup> 1 PKU [Emphases added.]
Age 13-35 months	3 well-child visits
Age 3-6	4 well-child visits
Age 7-12	4 well-child visits [Emphases added.]

1 Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.

- 2 “Well-child visit” means a visit to a primary care provider that includes the following elements; age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling. The schedule of these visits, through age 12 is based on the recommendations of the American Academy of Pediatrics.

Colorado Insurance Regulation 4-6-5, (effective February 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado’s small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.
2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado’s small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

Attachment 1

<b>Covered Preventive Services<sup>1</sup></b>	
All Children	Immunizations. Immunization deficient children are not bound by “recommended ages”.
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery. 6 well-child visits <sup>2</sup> 1 PKU [Emphases added.]
Age 13-35 months	3 well-child visits
Age 3-6	4 well-child visits
Age 7-12	4 well-child visits [Emphases added.]

- 1 Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.
- 2 “Well-child visit” means a visit to a primary care provider that includes the following elements; age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling. The schedule of these visits, through age 12 is based on the recommendations of the American Academy of Pediatrics.

Humana’s Basic and Standard Plans are not in compliance with Colorado insurance law in that the covered expenses reflected for Child Health Supervision Services do not reflect the mandated one (1) PKU to be provided from age 0-12 months

The small group plans reviewed are incorrect in the following ways:

- (1) Coverage for 5 well child visits is reflected for ages 0-12 months instead of the correct six (6) well child visits.
- (2) Coverage for two (2) well child visits is reflected for ages 13-35 months instead of the correct three (3) well child visits.
- (3) Coverage for three (3) well child visits is reflected for ages 3-6 years instead of the correct four (4) well child visits.
- (4) Coverage for three (3) well child visits is reflected for ages 7-12 years instead of the correct four (4) well child visits.

Page 173 of the National CovFirst plan,  
Page 163 of the National HDHP plan and  
Page 33 of the National POS plan reflect:

### **COVERED EXPENSES**

Benefits are provided for Child Health Supervision services for covered *dependents* up to age 13 based on the following schedule:

- Immunizations (covered immunizations are those recommended by the American Academy of Pediatrics). Immunization deficient children are not bound by the “recommended ages” of the American Academy of Pediatrics.
- Chicken pox vaccination for those who have not had the chicken pox.
- 5 well child visits and 1 PKU from 0-12 months
- 2 well child visits from 13-35 months
- 3 well child visits from 3-6 years
- 3 well child visits from 7-12 years

Benefits are limited to the above specified number of visits for each age group and are not subject to the deductible, or dollar limit provisions.

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National POS Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

**Recommendation No. 12:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-6-5 and Emergency Insurance Regulation 08-E-12, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has established procedures to ensure that all applicable forms have been corrected to reflect the correct and complete coverage to be provided for child health supervision services as required by Colorado insurance law, inclusive of those provisions set forth above.

.

<b>Issue E8: Failure, in some instances, to reflect correct or complete utilization review procedures.</b>
--

Section 10-16-113., C.R.S., Procedure for denial of benefits – internal review – rules, states in part:

...

- (1)(b) For the purposes of this section, a denial of a preauthorization for a covered benefit shall be considered a denial of a request for benefits and shall be made pursuant to the provisions of this section.

...

- (2) Following a denial of a request for benefits by the health coverage plan, such plan shall notify the covered person in writing. The content of such notification *and the deadlines for making such notification shall be made pursuant to regulations promulgated by the commissioner.* [Emphasis added.]

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, C.R.S., states in part:

...

Section 4 Definitions <sup>1</sup>

- M. “Prospective review” means utilization review conducted prior to an admission or course of treatment.

...

- O. “Retrospective review” means any utilization review that is not prospective review, but does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

...

- R. “Urgent care request” means:

1. A request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination that,
  - a. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; *or for persons with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently,* [Emphasis added.

Section 5 Compliance Requirements

...

- C. A health carrier that does not investigate claims involving utilization review within the time frames set out in this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier promptly investigate claims. (Section 10-3-1104(1)(h)(II), C.R.S.)

Section 6 Standard Utilization Review

...

- B. Prospective review determinations.
  - 1. Time period for determination and notification.
    - a. Subject to Subparagraph b. of Paragraph 1., a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, *but in no event later than fifteen (15) days after the date the health carrier receives the request.* Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with Subsection E. [Emphasis added.]
- C. Retrospective review determinations.
  - 1. For retrospective review determinations, a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination *within a reasonable period of time, but in no event later than thirty (30) days after the date of receiving the benefit request.* If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person in accordance with Subsection E. [Emphasis added.]

Section 7 Expedited Utilization Review

- A. Procedures
  - 1. A health carrier shall establish written procedures in accordance with this section for receiving benefit requests from covered persons and *for making and notifying covered persons of expedited utilization review with respect to urgent care requests.* For purposes of this section, "covered person" includes the designated representative of a covered person. [Emphasis added.]

In some instances, Humana's Basic and Standard plans and the small group plans are not in compliance with Colorado insurance law in that:

- (1) The definition of an Urgent-care claim (expedited review) is not complete as there is no mention of the resulting circumstances for a person with a physical or mental disability to qualify under an urgent care request.
- (2) The time periods reflected for decisions on appeals for Pre-service claims (30 days after receipt) and for Post-service claims (60 days after receipt) are incorrect. Appeals for Pre-service claims (prospective) require a fifteen (15) day time period from receipt of claim for a decision to be made. Post-service claims (retrospective) require a thirty (30) day time period from receipt of claim for a decision to be made.

Page 3 of the "Notices" pages for:  
The Basic HMO Limited Mandate plan,  
The Standard HMO plan,  
The National HDHP plan,  
The National POS plan and the  
National CovFirst plan reflect:

#### **Definitions**

**Urgent-care claim (expedited review)** means a claim for covered services to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Page 7 of the "Notices" pages for:  
The Basic HMO Limited Mandate plan,  
The Standard HMO plan,  
The National HDHP plan,  
The National POS plan and the  
National CovFirst plan reflect:

#### **Time periods for decisions on appeal**

Appeals of claims denials will be decided and notice of the decision provided as follows:

- **Urgent-care claims** – As soon as possible but no later than 72 hours after Humana receives the appeal request;
- **Pre-service claims** – Within a reasonable period but no later than 30 days after Humana **received** the appeal request; [Emphasis added.]

- **Post-service claims** – Within a reasonable period but no later than *60 days* after Humana receives the appeal request; [Emphasis added.]
- **Concurrent-care decisions** – Within the time periods specified above depending on the type of claim involved.

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National POS Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

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**Recommendation No. 13:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-113, C.R.S. and Colorado Insurance Regulation 4-2-17, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has established procedures to ensure that all applicable forms have been corrected to reflect the correct and complete procedures to be used for utilization review as required by Colorado insurance law, inclusive of those provisions set forth above.

<b>Issue E9: Failure to reflect all required information on the complaint forms to be given to enrollees who wish to register written complaints.</b>
---

Colorado Insurance Regulation 4-7-2, Concerning the Laws Regulating Health Maintenance Organization Benefit Contracts and Services in Colorado, promulgated under the authority of § 10-16-109, C.R.S., states in part:

...

Section 8      Other Requirements

...

D. Complaint System

...

2. An HMO shall provide complaint forms to be given to enrollees who wish to register written complaints. Such forms shall include the address *and telephone number to which complaints must be directed and shall specify any required time limits imposed by the HMO.* [Emphasis added.]

Humana's Complaint Form that is to be given to enrollees who wish to register written complaints is not in compliance with Colorado insurance law in that it does not include the following required items:

- (1) A telephone number that accompanies the address for registering written complaints
- (2) Any required time limits imposed by the Health Maintenance Organization

Form Name

Form Number

Humana Grievance/Appeal Request Form

GN\_97058\_RR 0205 (A0206)

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**Recommendation No. 14:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-7-2, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has corrected its Grievance/Appeal Request Form to include all items as required by Colorado insurance law, inclusive of those items set forth above.

<b>Issue E10: Failure, in some instances, to reflect the correct upper age limit for medically necessary therapy for Congenital Defects and Birth Abnormalities to be provided.</b>
---

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

...

(1.3) Early intervention services

(b)(IV) The limit on the amount of coverage for early intervention services specified in subparagraph (II) of this paragraph (b) shall not apply to:

(B) Services provided to a child who is not participating in part C and services that are not provided pursuant to an IFSP. *However, such services shall be covered at the level specified in paragraph (b) of subsection (1.7) of this section.* [Emphasis added.]

(1.7) Therapies for congenital defects and birth abnormalities.

(a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that *all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered child from the child's third birthday to the child's sixth birthday.* [Emphasis added.]

(b) The level of benefits required in paragraph (a) of this subsection (1.7) shall be the greater of the number of such visits provided under the policy or plan or twenty therapy visits per year each for physical therapy, occupational therapy, and speech therapy. Said therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy or yearly term of the enrollee coverage contract, *without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.* [Emphasis added.]

Two (2) of Humana's small group plans are not in compliance with Colorado insurance law in that the mandated coverage to be provided for therapies for congenital defects and birth abnormalities is incorrect. The benefit is to be provided from the child's birth to the child's sixth birthday.

The Covered Expenses section of the plans listed below indicate medically necessary physical, occupational, and speech therapy for the care of congenital defects and birth abnormalities is to be provided for children up to five (5) years of age instead of six (6) years of age.

Pages 26 and 150 of the National HDHP plan and  
Pages 30 and 160 of the National CovFirst plan reflect:

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**SCHEDULE OF BENEFITS**

**Physical medicine and rehabilitative services for the treatment of congenital defects and birth abnormalities from birth through age 4**

Pages 45 and 172 of the National HDHP plan and  
Pages 50 and 182 of the National CovFirst plan reflect:

**COVERED EXPENSES**

**Physical medicine and rehabilitative services benefit**

*Covered expenses* include *medically necessary* physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered *dependent* children up to five years of age without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

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**Recommendation No. 15:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has corrected all applicable forms to reflect the correct upper age limit for which therapies for congenital defects and birth abnormalities are to be provided for a covered child as required by Colorado insurance law.

**Issue E11: Failure, in some instances, to reflect the required coverage for mammography.**

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

...

(4) Low-dose mammography.

- (a) For the purposes of this subsection (4), “low-dose mammography” means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and film and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage provided to residents of this state, shall provide coverage for routine and certain diagnostic screening by low-dose mammography for the presence of breast cancer in adult women. Routine and diagnostic screenings provided pursuant to subparagraph (II) or (III) of this paragraph (a) shall be provided on a contract year or a calendar year basis by entities subject to part 2 or 3 of this article *and shall not be subject to policy deductibles. Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. The minimum benefit required under this subsection (4) shall be adjusted to reflect increases and decreases in the consumer price index.* . . . [Emphasis added.]

Three (3) of Humana’s small group plans are not in compliance with Colorado insurance law in that the Schedule of Benefits reflects that a non-network deductible will be applied to the benefit payable for preventive mammograms when using non-network health care practitioners.

Page 150 of the National CovFirst Plan,  
Page 143 of the National POS plan and  
Page 141 of the National HDHP plan reflect:

**SCHEDULE OF BENEFITS**

**Preventive screenings for covered persons 18 years of age or over**

**National CovFirst Plan**

<i>Non-network health care practitioner</i>	50% benefit payable after <i>non-network provider deductible</i>
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**National POS Plan & National HDHP Plan**

<i>Non-network health care practitioner</i>	70% benefit payable after <i>non-network provider deductible</i>
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**Market Conduct Examination  
Contract Forms**

**Humana Health Plan, Inc.**

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<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
National CovFirst Plan	CHMO 2004-C	10/01/07 to current
National POS Plan	CHMO 2004-C	10/01/07 to current
National HDHP Plan	CHMO 2004-C	10/01/07 to current

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**Recommendation No. 16:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has corrected all applicable forms to reflect the correct coverage for mammography as required by Colorado insurance law, inclusive of the provisions set forth above.

<b>Issue E12: Failure, in some instances, to reflect correct or complete benefits for prostate cancer screenings.</b>
---

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

...

(10) Prostate cancer screening.

- (a) All individual *and all group sickness and accident insurance policies*, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, *shall provide coverage for annual screening for the early detection of prostate cancer* in men over the age of fifty years and in men over the age of forty years who are in high-risk categories, which coverage by entities subject to part 2 or 3 of this article *shall not be subject to policy deductibles. Such coverage shall be the lesser of sixty-five dollars per prostate cancer screening or the actual charge for such screening. Such benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy.* This coverage shall be provided according to the following guidelines: [Emphases added.]

Humana's small group plans are not in compliance with Colorado insurance law in that the benefits expressed for prostate cancer screenings are incorrect and incomplete in the following ways:

Incorrect

- Colorado insurance law has a set amount which is used to calculate the benefit amount that will be paid. This amount of \$65.00 is not to be paid as a percentage of the charged amount after a deductible, but the lesser of sixty-five dollars per prostate cancer screening or the actual charge for such screening.
- This set amount is not subject to policy deductibles.

Incomplete

- There is nothing reflected to indicate that this benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under the policy in the HDHP and the Humana Coverage First 08 plans.
- Although it is stated that expenses include charges incurred for prostate screenings as recommended by the United States Preventive Services Task Force, nothing specific is reflected to indicate that the coverage provided is for annual screenings.

Page 141 of the National HDHP plan,  
Page 143 of the National POS plan and  
Page 150 of the National CovFirst Plan reflect:

**SCHEDULE OF BENEFITS**

**Preventive screenings for covered persons 18 years of age or over**

Excludes preventive endoscopic services, including but not limited to colonoscopy, proctosigmoidoscopy and sigmoidoscopy

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	100% benefit payable
<i>Non-network health care practitioner</i>	50% benefit payable after <i>non-network provider deductible</i> (National HDHP Plan)
	70% benefit payable after <i>non-network provider deductible</i> (National POS & National HDHP Plans)

Page 162 of the National HDHP plan,  
Page 164 of the National POS plan and  
Page 172 of the National CovFirst plan reflect:

**COVERED EXPENSES**

**Preventive screenings and immunizations**

*Covered expenses* include charges incurred by *you* for the following *preventive services* as recommended by the United States Preventive Services Task Force:

- A prostate specific antigen (PSA) test for a male *covered person* 40 years of age or older. The screening must be performed by a health care practitioner. The screening must consist of a:
  - PSA blood test; and
  - Digital rectal exam.

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National POS Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

**Recommendation No. 17:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has corrected all applicable forms to reflect the correct and complete coverage for prostate cancer screening as required by Colorado insurance law, inclusive of those provisions set forth above.

<b>Issue E13: Failure, in some instances, to reflect the mandated benefit for cervical cancer vaccination.</b>
--

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

...

(17) Cervical cancer vaccines.

- (a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, *shall provide coverage for the full cost of cervical cancer vaccination for all females for whom a vaccination is recommended by the advisory committee on immunization practices of the United States department of health and human services.* [Emphasis added.]
- (b) *The requirements of this subsection (17) shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued on or after January 1, 2008, and to all group accident and sickness policies and group health care service or indemnity contracts issued, renewed, or reinstated on or after January 1, 2008.* [Emphasis added.]

Humana's small group plans are not in compliance with Colorado insurance law in that the mandated coverage for the full cost of cervical cancer vaccination for all females for whom a vaccination is recommended is not reflected.

Pages 40 and 172 of the National CovFirst plan,  
Pages 32 and 164 of the National POS plan and  
Pages 35 and 162 of the National HDHP plan reflect:

## **COVERED EXPENSES**

### **Preventive services**

#### **Preventive screenings and immunizations**

*Covered expenses* include charges incurred by *you* for the following *preventive services* as recommended by the United States Preventive Services Task Force:

- Laboratory, radiology and/or endoscopic services to detect or prevent *sickness*.
- A baseline mammogram for a female *covered person* between the ages of 35 and 40 and an annual mammogram for a female *covered person* 40 years of age or older.
- Routine pap smear.

- A prostate specific antigen (PSA) test for a male *covered person* 40 years of age or older. The screening must be performed by a health care practitioner. The screening must consist of a:
  - PSA blood test; and
  - Digital rectal exam.
- Routine immunizations for *covered persons* under the age of 18. TB tine tests and allergy desensitization injections are not considered routine immunizations.

Immunizations against influenza and pneumonia, as determined by *us*. (Page 40-National CovFirst Plan and Page 32-National POS Plan)

Immunizations against influenza and pneumonia. (Page 172-National CovFirst Plan and Page 164-National POS Plan and Page 162-National HDHP Plan)

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National POS Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

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**Recommendation No. 18:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has corrected all applicable forms to reflect the mandated benefit for cervical cancer vaccination as required by Colorado insurance law, inclusive of the provisions set forth above

<b>Issue E14: Failure, in some instances, to provide for replacement or repair of prosthetic devices.</b>
---

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

...

(14) Prosthetic devices.

(a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for benefits for prosthetic devices that equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. secs. 1395k, 1395i, and 1395m and 42 CFR 414.202, 414.210, 414.228, and 410.100, as applicable to this subsection (14).

(b) For the purposes of this subsection (14) *"prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.*

...

(e) *Repairs and replacements of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss.*  
[Emphases added.]

Humana's small group plans are not in compliance with Colorado insurance law in that the description of coverage to be provided for prosthetic devices is more limiting than allowed. Coverage is to be provided for replacement of prosthetic devices, as well as repair, unless necessitated by misuse or loss. In two (2) of the plans nothing is reflected concerning replacement coverage and in one (1) of the plans, replacement is indicated as being a covered expense for prosthetic devices, but repair is not reflected.

Page 173 of the National HDHP plan and  
Page 183 of the National CovFirst plan reflect:

**COVERED EXPENSES**

**Additional covered expenses**

- Initial prosthetic devices or supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore the minimal basic function of a lost limb or eye. *Covered expense* includes repair of the prosthetic device UNLESS covered by the manufacturer or damage is due to misuse.

Page 174 of the National POS plan reflects:

**COVERED EXPENSES**

**Additional covered expenses**

- Initial prosthetic devices or supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore the minimal basic function of a lost limb or eye. Replacement is a *covered expense* if due to pathological changes or growth.

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National POS Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

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**Recommendation No. 19:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has corrected all applicable forms to reflect the correct coverage to be provided for prosthetic devices as required by Colorado insurance law, inclusive of the provisions set forth above.

<b>Issue E15: Failure to allow coverage to continue for an insured based solely on that individual's membership in the uniformed services of the United States.</b>
---

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

...

(16)(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall not refuse to provide coverage to an individual, *refuse to continue to cover an individual*, or limit the amount or extent of coverage available to an individual *solely based on that individual's membership in the uniformed services of the United States*. Nothing in this subsection (16) shall prohibit an insurer from excluding or limiting coverage for some other factor or preexisting condition. [Emphases added.]

(b) As used in this subsection (16):

(I) “Membership” means active duty, national guard, or reserve duty in the uniformed services of the United States, or retirement from such services.

(II) “Uniformed services of the United States” means the United States Army, United States Navy, United States Marine Corps, United States Air Force, United States Coast Guard, national oceanic and atmospheric administration commissioned officer corps, and the United States public health service commissioned corps.

Humana’s Basic and Standard plans and two (2) of its small group plans are not in compliance with Colorado insurance law in that they reflect that coverage will terminate on the date an insured enters full-time military, naval or air service.

Page 55 of the Basic HMO Limited Mandate plan,  
Page 59 of the Standard HMO plan,  
Page 196 of the National HDHP plan and  
Pages 75 and 206 of the National CovFirst plan reflect:

#### **TERMINATION PROVISIONS**

**Termination of coverage** (Basic and Standard HMO plans and National CovFirst plans)

**Termination of insurance** (National HDHP and National CovFirst plans)

The date of termination, as described in this “Termination Provisions” section may be the actual date specified or the end of that month, as selected by *your employer* on the Employer Group Application.

When *we* receive notification of a change in eligibility status in advance of the effective date of the change, coverage (insurance) will terminate on the actual date specified by the *employer* and/or *employee* or at the end of that month, as selected by *your employer* on the Employer Group Application.

Otherwise, coverage (insurance) terminates on the earliest of the following:

...

- The date *you* entered full-time military, naval or air service;

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

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**Recommendation No. 20:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R. S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has revised all applicable forms to indicate, as required by Colorado insurance law, that coverage shall not terminate based solely on an individual's membership in the uniformed services of the United States.

<b>Issue E16: Failure, in some instances, to reflect correct or complete Grievance and Appeal Procedures.</b>
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Section 10-16-113, Procedure for denial of benefits - internal review – rules, states in part:

- (1)(a) A health coverage plan shall not make a determination, in whole or in part, that it will deny a request for benefits for a covered individual on the ground that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient unless such denial is made pursuant to this section.

...

- (3)(a)(II)(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, *the carrier shall furnish the covered person and the covered person's representative with either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the covered person and the covered person's designated representative upon request; or*

- (B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, *the carrier shall furnish the covered person and the covered person's designated representative with either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the covered person's medical circumstances, or a statement that such explanation will be provided free of charge upon request.* [Emphasis added.]

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, C.R.S., states in part:

...

Section 6 Standard Utilization Review

...

C. Retrospective review determinations.

1. For retrospective review determinations, a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination within a reasonable period of time, *but in no event later than thirty (30) days after the date of receiving the benefit request.* If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person in accordance with Subsection E. [Emphasis added.]

...

Section 10 First Level Review

- J. A first level review decision involving an adverse determination issued pursuant to subsection G. shall include, in addition to the requirements of subsection I.:
1. The specific reason or reasons for the adverse determination, including the specific plan provisions and medical rationale;
  2. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term “relevant” is defined in subsection F.2., to the covered person’s benefit request;
  3. If the reviewers relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;
  4. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person’s medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request; and
  5. If applicable, instructions for requesting:
    - a. A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in paragraph 3. of this subsection; and
    - b. The written statement of the scientific or clinical rationale for the determination, as provided in paragraph 4. of this subsection.
  6. A description of the process to obtain a voluntary second level review, including:
    - a. The written procedures governing the voluntary second level review, including any required time frames for the review;
    - b. The right of the covered person to:
      - (1) Request the opportunity to appear in person before a health care professional (reviewer) or, if offered by the health carrier, a

- review panel of health care professionals, who have appropriate expertise, who were not previously involved in the appeal, and who do not have a direct financial interest in the outcome of the review;
- (2) Receive, upon request, a copy of the materials that the carrier intends to present at the review at least five (5) days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided by the carrier when practicable;
  - (3) Present written comments, documents, records and other material relating to the request for benefits for the reviewer or review panel to consider when conducting the review both before and, if applicable, at the review meeting;
    - (a) A copy of the materials the covered person plans to present or have presented on his or her behalf at the review should be provided to the health carrier at least five (5) days prior to the date of the review meeting.
    - (b) Any new material developed after the five-day deadline shall be provided to the carrier when practicable;
  - (4) Present the covered person's case to the reviewer or review panel;
  - (5) If applicable, ask questions of the reviewer or review panel; and
  - (6) Be assisted or represented by an individual of the covered person's choice, including counsel, advocates, and health care professionals;
- c. A statement that the carrier will provide the covered person, upon request, sufficient information relating to the voluntary second level review to enable the covered person to make an informed judgment about whether to submit the adverse determination to a voluntary second level review, including a statement that the decision of the covered person as to whether or not to submit the adverse determination to a voluntary second level review will have no effect on the covered person's rights to any other benefits under the plan, the process for selecting the decision maker, and the impartiality of the decision maker.
  - d. A description of the procedures for obtaining an independent external review of the adverse determination pursuant to Colorado Insurance Regulation 4-2-21 if the covered person chooses not to file for a voluntary second level review of the first level review decision involving an adverse determination.

Colorado Insurance Regulation 4-2-21, External Review of Benefit Denials of Health Coverage Plans, promulgated under the authority of §§10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states in part:

...

**Section 6 Request for External Review**

...

- D. All requests for external review shall include a signed consent, authorizing the carrier to disclose protected health information, including medical records, concerning the covered person that is pertinent to the external review.

...

**Section 8 Standard External Review**

...

- H. Independent external review entity notice requirements.

...

- 4. Upon carrier's receipt of the independent external review entity's notice of a decision pursuant to Paragraph 1, of this Subsection H. reversing the carrier's adverse determination; the carrier shall approve the coverage that was the subject of the carrier's adverse determination. *For concurrent and prospective reviews, the carrier shall approve the coverage within one (1) working day. For retrospective reviews, the carrier shall approve the coverage within five (5) working days.* The carrier shall provide written notice of the approval to the covered person or the designated representative within one (1) working day of the carrier's approval of coverage. The coverage shall be provided subject to the terms and conditions applicable to benefits under the health coverage plan. [Emphasis added.]

Humana's Basic and Standard and small group plans are not in compliance with Colorado insurance law in that the grievance and appeal procedures and pertinent "Notice" pages reflect incorrect and incomplete material in the following ways:

**Incorrect**

- (1) The time periods reflected for decisions on appeal of post-service claims is incorrect. A decision for retrospective review determinations is to be made no later than thirty (30) days after the date of receiving the benefit request, not sixty (60) days.

Incomplete

- (1) The rights of a covered person involving an independent external review does not include the right to receive from the health carrier, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits. There is a statement as follows: "Detailed appeal procedures are available upon request from us." A copy of these "detailed appeal procedures" was requested by the examiners and when provided they consisted of five (5) pages titled "Disclosure Process for Relevant Documentation Policy and Procedure" dealing with an overview, examples of relevant documents and the process for providing the documents necessary. The information provided was for any appeal. An insured should not have to request additional information from Humana to find out that the insured has a right to receive, free of charge, copies of all documents, records and other information relevant to the covered person's request for benefits.
- (2) The requirements for submitting a request for an independent external review do not reflect that all requests shall include a signed consent authorizing the carrier to disclose protected health information, including medical records, concerning the covered person that is pertinent to the external review.
- (3) There is notification that a request for a second level review may be submitted if the covered person is unable to resolve their concerns through the first level appeal process, but there is no other information concerning the process, rights of the covered person or time frames within which requests and determinations are to be made.
- (4) The timelines indicated in the plan for a standard external review do not reflect:
  - (a) That for concurrent and prospective reviews, the carrier shall approve the coverage within one (1) working day,
  - (b) That for retrospective reviews, the carrier shall approve the coverage within five (5) working days or,
  - (c) That the carrier shall provide written notice of the approval to the covered person or the designated representative within one (1) working day of the carrier's approval of coverage.

Page 7 of the "Notice Pages" for Humana's Basic and Standard and small group plans reflect:

**Time periods for decisions on appeal**

Appeals of claims denials will be decided and notice of the decision provided as follows:

- **Post-service claims** – Within a reasonable period but no later than *60 days* after Humana receives the appeal request. [Emphasis added.]

Page 76 of the Basic HMO Limited Mandate plan,  
Page 80 of the Standard HMO plan,  
Pages 91 and 217 of the National HDHP plan,  
Pages 88 and 214 of the National POS plan and  
Pages 96 and 227 of the National CovFirst plan reflect:

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## GRIEVANCE AND APPEAL PROCEDURES

### Independent external review

*You* must complete the first level appeal process prior to requesting an independent external review. If *you* are not satisfied with the outcome of *your* appeal, *you* or *your designated representative* may request a standard or expedited independent external review. The request must:

- Be submitted to *us* in writing within sixty (60) calendar days after *you* receive *our* final *adverse determination*; and
- Include a completed “Request for Independent External Review of Carrier’s Final Adverse Determination” form.

*You* or *your designated representative* may contact *us* at the following:

**HUMANA INSURANCE COMPANY  
GRIEVANCE AND APPEALS OFFICE  
P.O. BOX 14618  
LEXINGTON, KY 40512-4618  
(800) 558-4444**

Page 75 of the Basic HMO Limited Mandate plan,  
Page 79 of the Standard HMO plan,  
Pages 90 and 216 of the National HDHP plan,  
Pages 87 and 213 of the National POS plan and  
Pages 95 and 226 of the National CovFirst plan reflect:

### Second level appeal

If *we* are unable to resolve *your concerns through the first level appeal process*, *you* or *your designated representative* are entitled to submit a written *grievance*, requesting a second level review.

*You* or *your designated representative* may contact *us* at the following:

**HUMANA INSURANCE COMPANY  
GRIEVANCE AND APPEALS OFFICE  
P.O. BOX 14618  
LEXINGTON, KY 40512-4618  
(800) 558-4444**

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National POS Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

**Recommendation No. 21:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulations 4-2-17 and 4-2-21, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has revised all applicable forms to reflect complete and correct grievance and appeal procedures as required by Colorado insurance law, inclusive of those provisions set forth above.

<b>Issue E17: Failure, in some instances, to reflect the correct information concerning payment of premium for a newborn.</b>
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Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(1) Newborn children.

- (a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article *shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.* [Emphasis added.]

...

- (d) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of the newborn child and payment of the required premium must be furnished to the insurer or other entity within thirty-one days after the date of birth *in order to have the coverage continue beyond such thirty-one-day period.* [Emphasis added.]

Bulletin No. B-4.6, Mandatory Newborn Coverage and Premiums, states in part:

1. Background and Purpose

The purpose of this bulletin is to provide clarification regarding newborn coverage requirements and the collection of required premium as required in the Newborn Act, § 10-16-104(1), C.R.S. The Division of Insurance recognizes that the business of insurance has changed significantly since the Newborn Act was passed in 1975. The Act was initially intended to require coverage for newborn dependent children from the date of birth, prohibiting carriers from applying waiting periods before coverage could be effective or from applying pre-existing condition limitations for newborns.

The prevalence of managed care in the marketplace today, as well as other local and federal changes, including mandatory coverage of well child care and limits on pre-existing exclusions makes the interpretation of the Act more complex. After reviewing concerns raised by the industry, the Division has reviewed both the intent of the law, as well as proper application, in the current health insurance environment.

Bulletins are the Division's interpretations of existing insurance law or general statements of Division policy. Bulletins themselves establish neither binding norms nor finally determine issues or rights.

III. Division Position

*It is the responsibility of the carrier to provide health coverage for newborn dependent children from the date of birth.* In order for coverage to extend beyond the first thirty-one days, a carrier may require notification and payment of the required premiums within thirty-one days of the newborn dependent child's birth. [Emphasis added.]

A. Coverage during the first thirty-one days.

*Coverage must be provided automatically upon birth, continuing through the thirty-first day, without requiring notification or payment of premium. Such coverage shall be provided for the first thirty-one days of life and shall include all coverage available under the policy, including coverage for well-baby services as mandated in § 10-16-104 (11), C.R.S. [Emphasis added.]*

Humana's small group plans and its Basic Limited Mandate HMO Plan and Standard HMO Plan are not in compliance with Colorado insurance law in that they reflect that premium is due for any period of newborn dependent coverage whether the newborn dependent is enrolled or not. Colorado insurance law mandates coverage from the moment of birth for the first thirty-one (31) days and if the newborn is never enrolled in the plan, no premium can be charged for these thirty-one (31) days.

Pages 67 and 192 of the National HDHP plan,  
Pages 63 and 64 of the National POS plan and  
Pages 72 and 202 of the National CovFirst plan reflect:

**ELIGIBILITY AND EFFECTIVE DATES**

**Newborn dependent effective date**

- If we receive enrollment on, prior to, or within 31 days of the newborn's date of birth, *dependent* coverage is effective on the newborn's date of birth.
- If we receive enrollment more than 31 days after the newborn's date of birth, the newborn is considered a *late applicant*. The newborn's *effective date* of coverage will be the first of the month following receipt of the enrollment.
- If the *employee* already has *dependent* child coverage, and enrollment is not required, *dependent* coverage is effective on the newborn's date of birth. However, the *employee* must notify *us* of the birth.

**NOTE:** Premium is due for any period of newborn *dependent* coverage whether or not the newborn *dependent* is subsequently enrolled, unless specifically not allowed by applicable law.

**NOTE:** Premium is due for any period of newborn *dependent* coverage whether the newborn *dependent* is enrolled or not, unless specifically not allowed by applicable law. (National CovFirst Plan)

Page 53 of the Basic Limited Mandate HMO plan and  
Page 57 of the Standard HMO plan reflect:

**ELIGIBILITY AND EFFECTIVE DATES**

**Newborn dependent effective date**

- If we receive enrollment on, prior to, or within 31 days of the newborn's date of birth, *dependent* coverage is effective on the newborn's date of birth.

- If we receive enrollment more than 31 days after the newborn's date of birth, the newborn is considered a *late applicant*.
- If the *employee* already has *dependent* child coverage, and enrollment is not required, *dependent* coverage is effective on the newborn's date of birth provided the *employee* notify (sic) us of the birth within 31 days.

**Note:** Premium is due for any period of newborn *dependent* coverage whether or not the newborn *dependent* is subsequently enrolled, unless specifically not allowed by applicable law.

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National POS Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current

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**Recommendation No. 22:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has revised all applicable forms to reflect the correct provisions under which coverage is to be provided for newborns as required by Colorado insurance law, inclusive of the provisions set forth above.

**Issue E18: Failure to reflect that coverage is to be provided for urgent, non-routine after hours care for out-of-network services if an insured is temporarily traveling out of the service area.**

Colorado Insurance Regulation 4-6-5, (effective January 1, 2008), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

#### Section 4 Rules

##### A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and as conversion coverage pursuant to § 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.
2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to § 10-16-108, C.R.S.

#### BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

Effective January 1, 2008

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".* [Emphasis added.]
2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

Benefit Grid

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	<b>BASIC HMO PLAN</b>
<b>BASIC LIMITED MANDATE HEALTH BENEFIT PLAN</b>	<b>IN-NETWORK ONLY</b> (Out-of-network care is not covered except as noted.)
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	\$100 copay/visit. Out-of-network urgent care covered only if temporarily out of service area.

	<b>STANDARD HMO PLAN</b>
	<b>IN-NETWORK ONLY</b> (Out-of-network care is not covered except as noted.)
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	\$75 copay/visit  Out-of-network urgent care covered only if temporarily traveling out of service area.

Emergency Insurance Regulation 08-E-12, (effective January 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in

the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

**BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE  
OF COLORADO**

Colorado Division of Insurance

Effective January 1, 2009

3. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".* [Emphasis added.]
4. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

**Benefit Grid**

**JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:**

**INDEMNITY, PPO AND HMO**

**PART B: SUMMARY OF BENEFITS**

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	<b>BASIC HMO PLAN</b>
<b>BASIC LIMITED MANDATE HEALTH BENEFIT PLAN</b>	<b>IN-NETWORK ONLY</b> (Out-of-network care is not covered except as noted.)
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	\$100 copay/visit. Out-of-network urgent care covered only if temporarily out of service area.

	<b>STANDARD HMO PLAN</b>
	<b>IN-NETWORK ONLY</b> (Out-of-network care is not covered except as noted.)
<b>17. URGENT, NON-ROUTINE,</b>	\$75 copay/visit

<b>AFTER HOURS CARE</b>	Out-of-network urgent care covered only if temporarily traveling out of service area.
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Colorado Insurance Regulation 4-6-5, (amended February 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

Section 4 Rules

B. Plans

3. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and as conversion coverage pursuant to § 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.
4. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to § 10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE  
OF COLORADO

Colorado Division of Insurance

Effective February 1, 2009

5. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".* [Emphasis added.]
6. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

Benefit Grid

FEBRUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT  
PLANS:

INDEMNITY, PPO AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	<b>BASIC HMO PLAN</b>
<b>BASIC LIMITED MANDATE HEALTH BENEFIT PLAN</b>	<b>IN-NETWORK ONLY</b> (Out-of-network care is not covered except as noted.)
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	\$100 copay/visit. Out-of-network urgent care covered only if temporarily out of service area.

	<b>STANDARD HMO PLAN</b>
	<b>IN-NETWORK ONLY</b> (Out-of-network care is not covered except as noted.)
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	\$75 copay/visit  Out-of-network urgent care covered only if temporarily traveling out of service area.

Humana's Basic HMO Limited Mandate Plan and its Standard HMO Plan are not in compliance with Colorado insurance law in that nothing is reflected to indicate that coverage is to be provided for Urgent, Non-Routine, After Hours Care for out-of-network urgent care facility services if a member is temporarily traveling out of the service area.

Page 21 of the Basic LM HMO plan reflects:

**SCHEDULE OF BENEFITS**

**Urgent Care Services**

**Urgent care facility services**

Network provider	Covered in full after \$100 <i>copayment</i>
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Page 22 of the Standard HMO plan reflects:

Network provider	Covered in full after \$75 <i>copayment</i>
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<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current

---

**Recommendation No. 23:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of Emergency Insurance Regulation 08-E-12 and Amended Colorado Insurance Regulation 4-6-5, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has revised all applicable forms to reflect the correct coverage to be provided for urgent, non-routine, after hours care for out-of-network urgent care facilities as required by Colorado insurance law, inclusive of the provisions set forth above.

<b>Issue E19: Failure, in some instances, to allow coverage for transportation associated with hospice care.</b>
--

Colorado Insurance Regulation 4-2-8, Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care, promulgated under the authority of §§ 10-1-109 and 10-16-104(8)(d), C.R.S., states in part:

...

Section 5. Requirements for Hospice Care

...

C. Benefits for Hospice Care Services.

...

- (3) *The policy offering shall include the following benefits*, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above:

...

- (i) *Transportation* [Emphasis added.]

Colorado Insurance Regulation 4-6-5, (effective January 1, 2008), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

Section 4 Rules

...

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and as conversion coverage pursuant to § 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to § 10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR  
THE STATE OF COLORADO

Colorado Division of Insurance

...

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".* [Emphasis added.]
2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

Benefit Grid

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT  
PLANS:

INDEMNITY, PPO AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	<b>BASIC HMO PLAN</b>
<b>BASIC LIMITED MANDATE HEALTH BENEFIT PLAN</b>	<b>IN-NETWORK ONLY</b> (Out-of-network care is not covered except as noted.)
<b>26. HOSPICE CARE</b> <sup>18a, 18b</sup>	\$50 inpatient per diem copay  \$20 outpatient per diem copay

18a: Covered services are defined in Colorado Insurance Regulation 4-2-8.

	<b>STANDARD HMO PLAN</b>
	<b>IN-NETWORK ONLY</b> (Out-of-network care is not covered except as noted.)

26. HOSPICE CARE <sup>22a,</sup> <sub>22b</sub>	No copay (100% covered)
--	----------------------------

22a: Covered services are defined in Colorado Insurance Regulation 4-2-8.

Emergency Insurance Regulation 08-E-12, (effective January 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

#### Section 4 Rules

...

##### A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and as conversion coverage pursuant to § 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.
2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to § 10-16-108, C.R.S.

#### BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

...

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".* [Emphasis added.]

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled “Standard Health Benefit Plan”.

Benefit Grid

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	<b>BASIC HMO PLAN</b>
<b>BASIC LIMITED MANDATE HEALTH BENEFIT PLAN</b>	<b>IN-NETWORK ONLY</b> (Out-of-network care is not covered except as noted.)
<b>26. HOSPICE CARE</b> <sup>18a, 18b</sup>	\$50 inpatient per diem copay  \$20 outpatient per diem copay

18a: Covered services are defined in Colorado Insurance Regulation 4-2-8.

	<b>STANDARD HMO PLAN</b>
	<b>IN-NETWORK ONLY</b> (Out-of-network care is not covered except as noted.)
<b>26. HOSPICE CARE</b> <sup>22a, 22b</sup>	No copay (100% covered)

22a: Covered services are defined in Colorado Insurance Regulation 4-2-8.

Colorado Insurance Regulation 4-6-5, (amended February 1, 2009), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

...

Section 4 Rules

...

B. Plans

3. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to

this regulation and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and as conversion coverage pursuant to § 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

4. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to § 10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR  
THE STATE OF COLORADO

Colorado Division of Insurance

...

3. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".* [Emphasis added.]
4. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

Benefit Grid

FEBRUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT  
PLANS:

INDEMNITY, PPO AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	<b>BASIC HMO PLAN</b>
<b>BASIC LIMITED MANDATE HEALTH BENEFIT PLAN</b>	<b>IN-NETWORK ONLY</b> (Out-of-network care is not covered except as noted.)

<b>26. HOSPICE CARE</b> <sup>18a, 18b</sup>	\$50 inpatient per diem copay \$20 outpatient per diem copay
---	---

18a: Covered services are defined in Colorado Insurance Regulation 4-2-8.

	<b>STANDARD HMO PLAN</b> <b>IN-NETWORK ONLY</b> (Out-of-network care is not covered except as noted.)
<b>26. HOSPICE CARE</b> <sup>22a, 22b</sup>	No copay (100% covered)

22a: Covered services are defined in Colorado Insurance Regulation 4-2-8.

Humana's Basic Limited Mandate HMO Plan and Standard HMO Plan are not in compliance with Colorado insurance law in that they reflect an exclusion that is more limiting than allowed by Colorado insurance law. The mandated benefit of transportation for Hospice Care is not reflected under covered expenses and is included as an exclusion.

Page 47 of the Basic Limited Mandate HMO plan and  
Page 51 of the Standard HMO plan reflect:

#### **LIMITATIONS AND EXCLUSIONS**

- Lodging accommodations or transportation.

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current

#### **Recommendation No. 24:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-8, Emergency Insurance Regulation 08-E-12, and Colorado Insurance Regulation 4-6-5, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has revised all applicable forms to reflect that transportation is a mandated benefit to be included under hospice care as required by Colorado insurance law.

<b>Issue E20: Failure, in some instances, to reflect the mandated early intervention services to be provided as of January 1, 2008.</b>
---

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

...

(1.3) Early intervention services.

(a) As used in this subsection (1.3), unless the context otherwise requires:

...

(II) "Early intervention services" means services as defined by the division in accordance with part C that are authorized through an eligible child's IFSP but that exclude nonemergency medical transportation; respite care; service coordination, as defined in 34 CFR 303.12 (d) (11); and assistive technology, unless assistive technology is covered under the applicable insurance policy or service or indemnity contract as durable medical equipment.

(III) "*Eligible child*" means an *infant or toddler, from birth through two years of age*, who is an eligible dependent and who, as defined by the department pursuant to section 27-10.5-702 (9), C.R.S., *has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for services pursuant to section 27-10.5-102 (11) (c), C.R.S.*

(IV) "*Individualized family service plan*" or "*IFSP*" means a written plan developed pursuant to 20 U.S.C. sec. 1436 and 34 CFR 303.340 that authorizes early intervention services to an eligible child and the child's family. An IFSP shall serve as the individualized plan, pursuant to section 27-10.5-102 (20) (c), C.R.S., for an eligible child from birth through two years of age.

...

(VI) "*Qualified early intervention service provider*" or "qualified provider" means a *person or agency*, as defined by the division in accordance with part C, *who provides early intervention services and is listed on the registry of early intervention service providers pursuant to section 27-10.5-708 (1) (a), C.R.S.*

(b) (I) *All individual and group sickness and accident insurance policies or contracts issued or renewed by an entity subject to part 2 of this article on or after January 1, 2008, and all service or indemnity contracts issued or renewed by an entity subject to part 3 or 4 of this article on or after January 1, 2008, that include dependent coverage shall provide coverage for early*

*intervention services delivered by a qualified early intervention service provider to an eligible child. Early intervention services specified in an eligible child's IFSP shall qualify as meeting the standard for medically necessary health care services as used by private health insurance plans.*

- (II) *The coverage required by this subsection (1.3) shall be available annually to an eligible child from birth up to the child's third birthday and shall be limited to five thousand seven hundred twenty-five dollars, including case management costs, for early intervention services for each dependent child per calendar or policy year. For policies or contracts issued or renewed on or after January 1, 2009, and on or after each January 1 thereafter, the limit shall be adjusted by the division based on the consumer price index for the Denver-Boulder-Greeley metropolitan statistical area for the state fiscal year that ends in the preceding calendar year, or by such additional amount to be equal to the increase by the general assembly to the annual appropriated rate to serve one child for one fiscal year in the state-funded early intervention program if that increase is more than the consumer price index increase.*

Two (2) of Humana's small group plans are not in compliance with Colorado insurance law in that the coverage to be provided for early intervention services is not reflected in the certificates. Effective January 1, 2008, the mandated early intervention services were to be made available annually to an infant or toddler with significant delays in development or diagnosed with a physical or mental condition. The benefit is to be provided in accordance with Colorado insurance law start at the child's birth up to the third birthday.

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

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**Recommendation No. 25:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has revised all applicable forms to reflect the mandated benefit for early intervention services as required by Colorado insurance law, inclusive of those provisions set forth above.

**Issue E21: Failure to reflect correct information as to which Colorado counties have no participating providers.**

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration – repeal, states in part:

...

- (2)(d) The carrier shall provide, in conspicuous, bold-faced type, an understandable disclosure in policy contract materials, certificates of coverage for a policyholder, and marketing materials about the following:

- (I) Specific counties of the state where there are no participating providers;

Colorado Insurance Regulation 4-7-1, Health Maintenance Organizations, promulgated under the authority of §§ 10-16-109, 10-16-401(4)(o); and 10-16-403(2)(b), C.R.S., states in part:

...

Section 12 Provider Agreements

- A. *An HMO must establish that executed agreements between the HMO and the providers exist prior to licensure or granting of approval for an increase in geographic service area.* Provider agreements must be maintained in Colorado in the HMO's administrative office or other designated office for examination and shall be made available to the Commissioner upon request. [Emphasis added.]

Humana's certificates for the Basic Limited Mandate HMO, the Standard HMO Plan and the small group plans are not in compliance with Colorado insurance law as they have not relayed correct information to enrollees as to which counties have no participating providers. The following four (4) counties were added to Humana's service area with an approval date of January 11, 2008 and would have had executed agreements between the HMO and the providers prior to this approval date from the Division of Insurance.

- (1) Boulder
- (2) Elbert
- (3) El Paso
- (4) Teller

These four (4) counties, listed above, are reflected on the mandated listing of counties accompanying the certificates of coverage in which it is stated that contracted network providers are not actively maintained.

<u>Form Name</u>	<u>Form Number</u>	<u>Marketed</u>
Basic HMO Limited Mandate Plan	CO CHMOM-C	06/01/08 to current
Standard HMO Plan	CO-CHMOM-C	06/01/08 to current
National HDHP Plan	CHMO 2004-C	10/01/07 to current
National POS Plan	CHMO 2004-C	10/01/07 to current
National CovFirst Plan	CHMO 2004-C	10/01/07 to current

**Recommendation No. 26:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-704, C.R.S. and Colorado Insurance Regulation 4-7-1, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has revised all applicable forms to reflect the correct information as to which counties have no participating providers as required by Colorado insurance law.

**APPLICATIONS, NEW BUSINESS AND RENEWALS**

<b>Issue G1: Use of a group policy issued to the Employers Health Insurance Benefit Trust, a non-approved Trust, to offer conversion plans to eligible individuals.</b>
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Section 10-3-903.5, Jurisdiction over providers of health care benefits, states in part:

- (1) Notwithstanding any other provision of law, and except as provided in this section, any person or other entity which provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the division of insurance, unless such person or entity shows that while providing such services it is subject to the jurisdiction of another agency of this state, any subdivisions thereof, or the federal government.
- ...
- (4) Any person or other entity unable to show that it is subject to the jurisdiction of another agency of this state, any subdivision thereof, or the federal government, shall be subject to all appropriate provisions of this article regarding the conduct of its business.
- ...
- (7)(a) The provisions of this section and any other laws of this state that regulate insurance or insurance companies shall not apply to any multiple employer health trust which meets the requirements of paragraph (b) of this subsection (7) or any multiple employer welfare arrangement which meets the requirements of paragraph (c) of this subsection (7). Any such trust or arrangement shall be subject to the requirements of this subsection (7) and section 10-3-1104. *The exemption provided by this subsection (7) shall not apply to any entity if the division of insurance determines that its operation is hazardous to the public or to individuals receiving benefits.*
- (b) *A multiple employer health trust is any trust which is:*
- (I) *Sponsored, maintained, and funded by one or more entities of state government or political subdivisions of the state organized pursuant to state law and is for the benefit of the entity's employees; or*
- (II) *Established and maintained pursuant to the provisions of a collective bargaining agreement between one or more unions and employers or an association of employers for the benefit of employees who are covered by such agreement, and pursuant to which health benefits, wages, pension benefits, and other terms of employment have been bargained for in good faith and the sponsoring union provides services and benefits to its members other than health benefits. [Emphasis added.]*

Humana is not in compliance with Colorado insurance law in that it has established and continues to use a group policy issued to the Employers Health Insurance Benefit Trust to offer conversion plans to

individuals who are eligible for conversion coverage. Humana was notified by the Colorado Division of Insurance, Rates and Forms Section, on multiple occasions that this Trust was disapproved in Colorado. The basis for the disapproval was that the Trust was formed for the purpose of providing insurance, and that it did not meet the definition of a multiple employer trust as defined by Colorado insurance law.

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**Recommendation No. 27:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-3-903.5, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has discontinued use of the group policy issued to the Employers Health Insurance Benefit Trust to offer conversion plans to eligible individuals as required by Colorado insurance law.

<b>Issue G2: Failure to ensure that there are no restrictive underwriting practices and standards for small employer groups.</b>
--

Section 10-16-102, C.R.S, Definitions, states in part:

...

- (40) *"Small employer" means any person, firm, corporation, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, the majority of whom were employed within this state and that was not formed primarily for the purpose of purchasing insurance. On and after January 1, 1996, "small employer" includes a business group of one. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. [Emphasis added.]*

Section 10-16-105, C.R.S., Small group sickness and accident insurance-guaranteed issue- mandated provisions for basic health benefit plans- rules- benefit design, states in part:

...

- (12) *In the case of an employer that was not in existence throughout the preceding calendar quarter, the determination of whether such employer is a small or large employer shall be based on the average number of employees that is reasonably expected such employer will employ on business days in the current calendar year. [Emphasis added.]*

In the review of information provided to agents in Humana's Connections Newsletter as circulated to Colorado agents, Humana stated:

**"Underwriting changes:  
Feb. 1, 2009, new case effective dates  
Employee-level health questions required  
for all new business (1-99 employees)  
New case eligibility change (1-99 employees)**

*To simplify the documentation requirements for recently started businesses, a business must be operational for a minimum of six months to be eligible for coverage with Humana Small Business. This requirement will eliminate questions about businesses that may be too new to have filed payroll or a state wage and tax report" [Emphasis added]*

Humana is not in compliance with Colorado insurance laws, in that their underwriting criteria for small groups as stated in Humana's Agent Newsletter is more restrictive with regard to eligibility of new small groups than allowed by Colorado insurance law.

**Recommendation No. 28:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide documentation demonstrating why it should not be considered in violation of §§ 10-16-102 and 10-16-105, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has discontinued use of restrictive underwriting practices for eligible small employer groups as required by Colorado insurance law, inclusive of the restrictive use set forth above.

<p><b><u>CANCELLATIONS/NON-RENEWALS/DECLINATIONS</u></b></p>
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<b>Issue H1: Failure to reflect a definition of “Significant break in coverage” on Certificates of Creditable Coverage.</b>
---

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

...

- (b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than *ninety days* prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. The method of crediting and certifying coverage shall be determined by the commissioner by rule. [Emphasis added.]

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated under the authority of §§ 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

...

Section 4. Definitions

A. “Significant break in coverage” means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. *For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days.* For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.

Section 5. Rules

...

B. Colorado law concerning creditable coverage. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

3. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, if such creditable coverage was

continuous to a date not more than *ninety (90) days* prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.

4. Application of the rules regarding breaks in coverage can vary between issuers located in different states, and between fully insured plans and self-insured plans within a state. The laws applicable to the health coverage plan that has the pre-existing condition exclusion will determine which break rule applies.
5. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance *must issue certificates of creditable coverage that reflect the definition of “Significant break in coverage” found in Section 4.A. of this regulation.* [Emphases added]

The Certificate of Prior Creditable Coverage provided to individuals whose coverage was cancelled was not in compliance with Colorado insurance law in that the form did not reflect the definition of “significant break in coverage” as required by Colorado insurance law. Failure to include this required information in the Certificates of Prior Creditable Coverage sent to members whose coverage had been cancelled, may prevent those individuals from becoming aware of the rules regarding creditable coverage and the time limit for obtaining replacement coverage in order to avoid the application of preexisting condition exclusions.

The incidence of error for Certificates of Creditable Coverage is as follows:

**Certificates of Creditable Coverage**  
**July 1, 2007-June 30, 2009**

<b>Population</b>	<b>Sample</b>	<b>Incidence of Error</b>	<b>Percentage to Sample</b>
108	79	79	100%

The following Certificate of Creditable Coverage is not in compliance with Colorado insurance law:

Form

Date

Certificate of Prior Creditable Coverage

Undated

---

**Recommendation No. 29:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-118, C.R.S. and Colorado Insurance Regulation 4-2-18, which was promulgated under the Commissioner’s authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has implemented procedures to ensure that all Certificates of Creditable Coverage reflect the complete definition of a “Significant break in coverage” in compliance with Colorado insurance law.

**Issue H2: Failure, in some instances, to offer each member of a terminating group a choice of the Basic or Standard Health Benefit plan.**

Section 10-16-108(4), C.R.S., Conversion and continuation privileges, states in part:

...

(4) Special provisions for small group health benefit plans

- (a) Effective January 1, 1995, *each small employer carrier shall, upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, offer to any individual the choice of a basic or standard health benefit plan, except as provided in paragraph (b) of this subsection (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel.* [Emphasis added.]

The examiners reviewed a sample of seventy-nine files that were randomly selected from a population of 104 small groups whose coverage canceled during the exam period of July 1, 2007 through June 30, 2009. Humana did not offer all cancelled or terminating groups an offer of a Basic or Standard health benefit plan as required under Colorado insurance law. There was no indication in any of the cited cases that the group's coverage had been replaced with another group plan.

The incidence of error is as follows:

**Cancelled Small Group Policies  
July 1, 2007-June 30, 2009**

Population	Sample Size	Number of Exceptions	Percentage of Sample
104	79	17	22%

Humana is not in compliance with Colorado insurance law in that in seventeen (17) cases (or 22% of the sample), upon termination of the group policy Humana failed to offer members of the terminating small group a choice of the basic or standard health benefit plan as required by Colorado insurance law.

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**Recommendation No. 30:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-108, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has implemented procedures to ensure that all cancelled or terminated small groups are offered a choice of Basic or Standard Health Benefit Plans in compliance with Colorado insurance law.

**CLAIMS**

**Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.**

Section 10-16-106.5., C.R.S, Prompt Payment of Claims – legislative declaration states, in part:

...

- (2) *As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean Claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.*

...

- (4)(a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.*
- (b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).*
- (c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier. [Emphases added.]*

Humana is not in compliance with Colorado insurance law in that:

**ELECTRONIC CLAIMS ADJUDICATED 30 DAYS OR MORE AFTER RECEIPT**

Population	Sample Size	Number of Exceptions	Total Error Rate
331*	82	22	27%

(\*2.6% of all electronic claims processed.)

Twenty-two (22) of 82 claims randomly selected from the total population of 331 electronic claims

adjudicated more than thirty (30) days after receipt appeared to be clean claims that were not paid, denied or settled within the required time frame.

**NON-ELECTRONIC CLAIMS ADJUDICATED 45 DAYS OR MORE AFTER RECEIPT**

Population	Sample	Number of Exceptions	Total Error Rate
191*	76	9	12%

(\*7.4% of all non-electronic claims processed.)

Nine (9) of 76 non-electronic claims randomly selected from the total population of 191 non-electronic claims adjudicated more than forty-five (45) days after receipt appeared to be clean claims that were not paid, denied or settled within the required time frame

**CLAIMS ADJUDICATED 90 DAYS OR MORE AFTER RECEIPT**

Population	Sample	Number of Exceptions	Total Error Rate
145*	76	10	13%

(\*<1% of all claims processed.)

Humana failed to pay, deny or settle ten (10) of seventy-six (76) claims randomly selected from a total population of 145 claims not paid, denied or settled within the required ninety (90) calendar days. There was no indication in the claim records that any of the cited claims involved fraud. Absent fraud, all claims are to be paid, denied, or settled within ninety (90) calendar days of receipt.

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**Recommendation No. 31:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has reviewed and modified its claims processing quality controls to ensure that all claims are adjudicated within the above cited required time periods as required by Colorado insurance law.

**UTILIZATION REVIEW**

<b>Issue K1: Failure, in some instances, to include a consultation with an appropriate clinical peer when evaluating first level review appeals.</b>
--

Section 10-16-113, Procedure for denial of benefits - internal review – rules, states in part:

- (1)(a) A health coverage plan shall not make a determination, in whole or in part, that it will deny a request for benefits for a covered individual on the ground that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient unless such denial is made pursuant to this section.

...

- (3)(b)(I) ... A health coverage plan shall specify that an appeal from the denial of a request for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient shall include a two-level internal review of the decision, followed by the right of the covered person to request an external review under section 10-16-113.5. The covered person shall have the option of choosing whether to utilize the voluntary second-level internal appeal process. The commissioner shall promulgate rules for such benefits denials that reflect the requirements in 29 CFR 2560.503-1 (a) to (j). In addition, the commissioner shall promulgate rules specifying the elements of and timelines for external review appeals procedures, including but not limited to the review of appeals requiring expedited reviews and authorizations by the covered individual requesting an independent external review for access to medical records necessary for the conduct of the external review. The commissioner shall consult with and utilize public and private resources, including but not limited to health care providers, in the development of such rules.

...

- (IV) The carrier shall notify the covered person of his or her right to appeal a denial of benefits through a two-level internal review process and that the second level of internal review may be utilized at the option of the covered person.
- (V) The first-level appeal shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer; except that, in the case of dental care, the first-level appeal may be evaluated by a dentist, who shall consult with an appropriate clinical peer or peers, unless the reviewing dentist is a clinical peer. The physician or dentist and clinical peers shall not have been involved in the initial adverse determination. A person who was previously involved with the denial may answer questions.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

...

Section 10. First Level Review

...

E Conduct of first level reviews.

...

2. *First level reviews shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer.* The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions.  
[Emphasis added]

The examiners reviewed the entire population of fifty-five (55) first-level utilization review appeal files initiated by “covered persons” or their representative(s) during the examination period of July 1, 2007 to June 30, 2009. One file was removed from review because it was an Iowa case, leaving fifty-four (54) files reviewed.

Humana did not meet the requirements of Colorado insurance law in that all fifty-four (54) first-level utilization review decisions did not reflect a consultation with an appropriate clinical peer by the physician or others reviewing the appeal. In addition, it did not appear that the physician that performed the review was considered a clinical peer for the condition that was the subject of the review.

The incidence of error is as follows:

**First Level Utilization Review  
July 1, 2007-June 30, 2009**

<b>Population</b>	<b>Sample Size</b>	<b>Number of Exceptions</b>	<b>Total Error Rate</b>
54	54	54	100%

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**Recommendation No. 32:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17, which was promulgated under the Commissioner’s authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has implemented procedures to ensure that all first level reviews are evaluated by a physician who shall consult with an appropriate clinical peer or peers unless the reviewing physician is a clinical peer, as required by Colorado insurance law.

**Issue K2: Failure, in some instances, to notify and issue a First Level Appeal decision no later than thirty (30) days after receipt of the grievance requesting the first level review.**

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

...

Section 10. First Level Review

...

G. Notification Requirements.

...

3. *With respect to a request for a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review.*
4. *With respect to a request for a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review. [Emphases added.]*

The examiners reviewed the entire population of fifty-five (55) first-level utilization review appeal files initiated by "covered persons" or their representative(s) during the examination period of July 1, 2007 to June 30, 2009. One file was removed from review because it was an Iowa case, leaving fifty-four (54) files reviewed. Humana did not meet the requirements of Colorado insurance law in that in twelve (12) of the fifty-four (22% of the sample) first-level utilization reviews notification of the review decision was not provided no later than thirty (30) days after receipt of the grievance requesting the first level review.

**First Level Utilization Review  
July 1, 2007-June 30, 2009**

Population	Sample Size	Number of Exceptions	Total Error Rate
54	54	12	22%

**Recommendation No. 33:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17, which was promulgated under the Commissioner's authority set forth at § 10-1-109(1). In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division of Insurance that it has implemented procedures to ensure that all utilization review determinations are made within the above cited time periods required by Colorado insurance law.

**Issue K3: Failure, in some instances, to have written denials of requests for benefits as not medically necessary, appropriate, effective, or efficient signed by a licensed physician.**

Section 10-16-113, C.R.S., Procedure for denial of benefits-rules, states in part:

...

- (4) All written denials of requests for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient *shall be signed by a licensed Physician* familiar with standards of care in Colorado.  
[Emphasis added.]

The examiners reviewed the entire population of fifty-five (55) first-level utilization review appeal files initiated by “covered persons” or their representative(s) during the examination period of July 1, 2007 to June 30, 2009. One file was removed from review because it was an Iowa case, leaving fifty-four (54) files reviewed.

Humana is not in compliance with Colorado insurance law in that nineteen (19) of fifty-four first-level utilization review decision letters were signed by a Specialist or Grievance and Appeal Specialist and not by a licensed physician familiar with standards of care as required under Colorado insurance law.

The following shows the incidence of error:

**First Level Utilization Review  
July 1, 2007-June 30, 2009**

Population	Sample Size	Number of Exceptions	Total Error Rate
54	54	19	35%

**Recommendation No. 34:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-113, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has implemented procedures to ensure that all written denials of requests for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient shall be signed by a licensed physician familiar with standards of care in Colorado as required by Colorado insurance law.

<b>Issue K4: Failure to include correct information regarding preauthorization in utilization review approval letters.</b>
--

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

- (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

...

- (b) *False information* and advertising generally: *Making*, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading; [Emphasis added.]

Section 10-16-704, C.R.S., Network Adequacy, states in part:

...

- (5) *When a treatment or procedure has been preauthorized by the plan, benefits cannot be retrospectively denied except for fraud and abuse.* If a health carrier provides preauthorization for treatment or procedures that are not covered benefits under the plan, the carrier shall provide the benefits as authorized with no penalty to the covered person. [Emphasis added.]

Colorado Division of Insurance Bulletin No. B-4.13 Preauthorization for Treatments or Procedures by Health Plans issued May 8, 2007, states in part:

### **I. Background and Purpose**

... Carriers often contract with third party to perform medical necessity or utilization review. The results of these reviews are often provided to the insureds or their providers before the carrier has made its coverage determination. In an attempt to reserve the right to make a subsequent coverage determination, the initial notification sometimes contains disclaimer language stating that coverage is contingent upon a subsequent level of review. After notification of approval at the initial review for medical necessity, some carriers are later denying coverage for the treatment or procedure which was the subject of the initial approval.

...

### **III. Division Position**

Colorado law states that once a carrier has “preauthorized” a treatment or procedure, the carrier cannot retrospectively deny the treatment or procedure, except for fraud and abuse, even where the benefit is not covered under the plan. See § 10-16-704(4), C.R.S. In addition, the statute prohibits the carrier from imposing a penalty on the insured for coverage of the benefit where the treatment or procedure was preauthorized. Covered persons and providers often do not distinguish between a medical necessity determination and a coverage determination, and act upon the initial medical necessity determination alone.

*To avoid any confusion between the types of determination, the Division interprets this statute to mean that whenever a treatment or procedure is approved, irrespective of the terminology used by the carrier when reviewing the claim (e.g., precertification, preauthorization, medical necessity or utilization review), the carrier cannot subsequently deny coverage. In other words, it is incumbent upon the carrier to make its coverage determination prior to the delivery of any medical necessity determination or other form of preauthorization to the covered person or their provider. The exceptions are for fraud and abuse or where the insured loses coverage after approval, but before actually obtaining the treatment or procedure. In addition, the carrier cannot reduce the benefit which is subject to the initial review in any manner, such as by requiring the insured to pay a higher co-pay than would normally be due under the plan. [Emphasis added.]*

Carriers cannot avoid the statutory requirement by including a disclaimer in the notice initially approving the treatment or procedure. For example, a carrier cannot notify a provider and/or insured that a particular treatment or procedure has passed a certain level of review, but final approval is contingent upon additional review. To do so is a violation of the intent of the statute to prohibit retrospective denials after “preauthorization.”

The examiners reviewed the sample of 115 utilization review approvals made during the examination period. In all 115 instances Humana was not in compliance with Colorado insurance law in that the letter of approval of services provided to the provider and/or covered person implies that the claim *may* be retrospectively denied for reasons other than those provided for in § 10-16-704(4) C.R.S. The lack of clarity of the letter and the phrase “*Any payment or coverage is subject to all plan provisions*” may constitute a deceptive practice or act.

The following shows the incidence of error:

**Utilization Review Approvals  
July 1, 2007-June 30, 2009**

Population	Sample Size	Number of Exceptions	Total Error Rate
4,103	115	115	100%

Further, the letter’s implied message that a claim may be denied subsequent to preauthorization for treatment for procedures or services that are not covered benefits under the plan is contrary to the requirements of Colorado insurance law that states the carrier shall provide the benefits as authorized with no penalty to the covered person.

Humana’s preauthorization of services letter states in part:

**“LETTER OF APPROVAL OF SERVICES**

Humana values our relationship with our members, and our goal is to provide exceptional customer service. We would like to take this opportunity to explain the approval of [covered

person's] inpatient admission at [facility] on 1/1/2009 through 1/5/2009, for a total of 4 days.

We have determined that the services requested are Medically Necessary as defined in the Benefit Plan Document. Any payment or coverage is subject to all plan provisions.

If you would like to contact our office regarding this or future services, please utilize the precertification phone number on the back of your ID card. If you are speech or hearing impaired, please call 1-800-325-2025. We are available Monday through Friday, 8:00 a.m. until 6:00 p.m.”.

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**Recommendation No. 35:**

No later than thirty (30) days from the date this report is adopted, Humana shall provide written documentation demonstrating why it should not be considered in violation of §§ 10-3-1104, 10-16-704, C.R.S. In the event Humana is unable to provide such documentation, it shall provide written evidence to the Division that it has implemented procedures to ensure that all written approval of preauthorization for covered benefits are in compliance with Colorado insurance law, inclusive of the provisions set forth above.

<b>SUMMARY OF ISSUES AND RECOMMENDATIONS</b>	<b>Rec. No.</b>	<b>Page No.</b>
<b>OPERATIONS AND MANAGEMENT</b>		
<b>Issue A1: Failure, in some instances, to maintain records required for market conduct purposes.</b>	<b>1</b>	<b>19</b>
<b>Issue A2: Failure to maintain an Access Plan as required by Colorado insurance law.</b>	<b>2</b>	<b>20</b>
<b>Issue A3: Failure to annually provide required information to enrollees regarding the financial condition and any organizational changes to the health maintenance organizations.</b>	<b>3</b>	<b>21</b>
<b>Issue A4: Failure, in some instances, to properly certify policy forms and use of non-compliant forms.</b>	<b>4</b>	<b>22</b>
<b>COMPLAINTS</b>		
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**Examination Report Submission**

**State Market Conduct Examiner**

**Jeffory A. Olson, CIE, FLMI, AIRC, ALHC  
Examiner-In-Charge**

**And**

**Independent Contract Examiners**

**Kathleen M. Bergan, CIE, MCM**

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**Lynn Zukus, AIE, FLMI**

**Submit this report on this 4<sup>th</sup> day of March, 2011 on behalf of:**

**The Colorado Division of Insurance  
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Denver, Colorado 80202**